KLINISCHE STUDIEN AN NARKOSE-INDUZIERENDEN AGENTIEN
XXX: VENÖSE FOLGERSCHEINUNGEN NACH ATHANOL-NARKOSE

ZUSAMMENFASSUNG
Die Wirkung einer raschen Infusion von 5-10prozentiger (Gewichtsprozent) Alkohollösung auf die Venen wurde an etwa 400 Patienten untersucht. Die Infusion der bis zu 550 ml dosierten Lösung wurde innerhalb von 4-5 Minuten schnell durchgeführt. Eine moderate hypocapnia should be maintained after discontinuing first the halothane and subsequently the nitrous oxygen preferably until the pre-operative level of consciousness has been regained. This may take several hours. Under no circumstance can it be justified to "wake up" the patient using a rebreathing system for letting carbon dioxide accumulate. Controlled hyperventilation during recovery from anaesthesia is especially important in head injury cases where risks of vomiting and aspirating gastric contents are increased.

(4) The blood pressure decreases with the combined effect of chlorpromazine, barbiturates, halothane, and hypocapnia. Especially in the initial phase of anaesthesia, and if surgery is not carried out, the blood pressure may fall quite markedly. As is the general practice in most clinics a moderate level of hypotension (at a blood pressure level of approximately 80 per cent of the pre-operative or the assessed normal level) is acceptable. Development of lower pressures is counteracted by fluid administration (we use plasma or glucose 6 per cent in an amount of 1-2 litres if no bleeding occurs) and with hypertonic urea (we use 0.75 to 1.00 g/kg).

No comments will be given here regarding the use of the profound hypotension used for certain types of neurosurgery. Such lowering of the blood pressure is, when necessary, easily achieved by means of postural tilt and the occasional use of hypotensive agents; it should as a matter of principle be of as brief duration as possible and preferably combined with moderate hypothermia (30-32°C). A discussion of the various measures used for using brain bulk also lies beyond the scope of this discussion.

(5) A timely warning which was explicitly made in the Editorial concerns brief halothane anaesthesias in patients with intracranial space-occupying lesions. In such anaesthetics, often used in conjunction with neuroradiological studies, precisely the same precautions as discussed above must be taken, namely: careful induction; intubation, controlled moderate hypocapnia maintained during and after anaesthesia until adequate recovery has been reached and with proper precautions against vomiting and aspiration; as the "stimulus" of surgery is absent, hypotension is apt to be relatively more pronounced and it must be counteracted by fluid administration and/or hyperosmotic therapy. Without proper attention to these problems a most dangerous triad of intracranial hyper-