ABSTRACTS

Editorial Comment: A fixed style of presentation for this department of ANESTHESIOLOGY has purposely not been defined. It is the wish of the Editorial Board to provide our readers with the type of abstract they desire. Correspondence is invited offering suggestions in regard to the length of abstracts, character of them, and source of them. The Board will appreciate the cooperation of the membership of the Society in submitting abstracts of outstanding articles to be considered for publication.

HIMALSTEIN, M. R.: *Technique for the Administration of Topical Anesthesia in Endoscopy.* North Carolina M. J. 12: 109–110 (March) 1951.

"My interest in the subject of topical anesthesia began when one death and several reactions due to topical anesthesia occurred at the Oteen Veterans Hospital. . . . After perusing the literature, sending questionnaires to the members of the American Broncho-Esophagological Association, and trying various techniques (drugs singly and in combination), and drug concentrations, we modified our procedure at Oteen. . . . This procedure was developed as a result of our experience in administering 4,493 anesthetics for endoscopic procedures performed at Oteen since 1946. Since it was adopted, we have not had a single reaction to topical anesthesia. . . .

"We found that a 2 per cent cocaine spray was sufficient to lessen the pharyngeal reflex and relax the aditus laryngis. By accurate measurement of the drug solution, before and after spraying, it was found that the average patient required 2 cc. of this solution. . . . A Devilbiss number 127 atomizer is used, as this allows the bottle and bulb to be operated with one hand, leaving the other hand free to hold the tongue initially, and later the laryngeal mirror. Maximum compression of the bulb is avoided until the spray burst can be directed into the aditus under mirror visual control. The patient is advised not to swallow the sprayed material, but to clear his throat and expectorate all excess solution. The soft palate and posterior pharyngeal wall are given several weak bursts in one application. The atomizer tip is then bent to an angle of aproximately 90 degrees, and several weak bursts are directed toward the posterior surface of the epiglottis. The patient should now tolerate the presence of the mirror. Under mirror control, repeated weak applications are directed behind the epiglottis until the aryepiglottic muscle fibers relax and a direct view of the glottis is obtained. Several heavy bursts are then directed toward the glottis. . . .

"It is now time to instill cocaine directly into the larynx with a syringe and cannula. We use a 3 cc. syringe, to which is attached a malleable silver eustachian catheter. The cannula is so bent for each case as to allow delivery of the solution into the larynx, avoiding contact between the cannula and the epiglottis. A total of 2 cc. of a 5 per cent solution of cocaine is delivered. The solution is instilled a single drop at a time."

A. A.

PINCH, CHARLES, AND GEOGHEGAN, J. J.: *Barbiturate Poisoning Treated with Modified Electrotherapy.* Canad. M. A. J. 64: 233–234 (March) 1951.

"Some psychiatrists know from experience with electro-stimulation of the