SEVERE BARBITURATE-MORPHINE POISONING: REPORT OF CASE

This case is reported for two reasons: because of (1) the unusually prolonged unconsciousness from massive narcotic overdose, and (2) the omission of the usual regimen of analeptic drugs.

A young man ingested 10 Gm. of phenobarbital late one night, and took 2 grains of morphine, either intravenously or hypodermically. (These doses were admitted later.) When he was found at 8:00 a.m. of the first day, his respiration was extremely poor because of obstruction and depression. The pupils were pinpoint. Treatment that day consisted of oropharyngeal administration of oxygen with an oral airway, and suctioning of the pharynx. Possibly as a result of obstruction, cyanosis and very inadequate breathing occurred around 2:00 p.m. This cleared up soon, but it was decided that a better airway was needed. A resident in anesthesiology inserted a Murphy tube (blind nasal) and instructed the nursing personnel in the use of deep catheter suction. Oxygen was given by catheter into the tube. Considerable mucus was aspirated when suction was applied thereafter, ten or fifteen times a day.

On the second day the nasotracheal tube was changed. The temperature rose to 104.8 F. All reflexes were absent. On the third day the nasotracheal tube was changed. The temperature was 103.7 F. On the fourth day the nasotracheal tube was changed under direct vision. There was no response to irritation by the suction catheter, but the patient coughed fairly vigorously as the tracheal tube was inserted. Urinalysis showed 122.2 mg. of barbiturate. per 100 cc.

On the fifth day the patient could not open his mouth wide enough for laryngoscopy. The tube was changed and a clean one inserted blindly. Later that day, tracheotomy was done at my suggestion. There was slight reflex activity.

The patient opened his eyes on the sixth day, but made no attempt at purposeful activity. On the seventh day he tried to speak but was incoherent. He spoke coherently on the eighth day, but was not aware of any recent events. The tracheotomy tube was removed on the tenth day. By the fifteenth day the patient's condition was normal, although he was still confined to bed.

For four days it was thought that the patient might die. On the fifth day we feared that he might be in a vegetative state as a result of lack of oxygen the night the phenobarbital and morphine were taken. The end results indicate that the prolonged unconsciousness was chiefly of pharmacologic origin rather than an initial hypoxia.

Following the suggestion of Nilsson (1), we relied on a patent airway, oxygen therapy and the use of catheter suction to prevent atelectasis and pneumonia. The internists could not be entirely dissuaded from using caffeine hypodermically, but there was no evidence of any particular effect at any time nor was it expected. Neither metrazol® nor picrotoxin was used. Close attention was given to the circulation, but serious hypotension was a problem only on the first day. It was treated by intravenous infusions of glucose and saline solution.

REFERENCE

1. Nilsson, Eric: On Treatment of Barbiturate Poisoning: A Modified Clinical Aspect, Acta med. scand. Suppl. 253 (1951) p. 1–127.

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AN ADAPTER FOR THE FOREGGER TO-AND-FRO ASSEMBLY

The routine setup for inducing anesthesia with the Foregger to-and-fro assembly is illustrated in figure 1. When endotracheal intubation is desired, the metal elbow and the delivery tube are disconnected. A special canister adapter with nipple inlet is then attached to the canister and the delivery tube is connected to the canister adapter. The latter is connected to the catheter slip joint, as shown in figure 2.

A new metal adapter has been devised to save valuable time in making the necessary connections when intubation has been accomplished. The adapter consists of a metal connection which can be placed between the socket adapter of the face piece and the

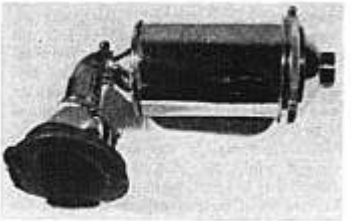

FIG. 1.

canister adapter with nipple inlet, as shown in figure 3. With this setup the change-over from mask to endotracheal catheter is simple and rapid; all that is necessary is to remove the canister adapter from the new connection and place the canister adapter directly on the catheter slip joint. When anesthesia is maintained by face

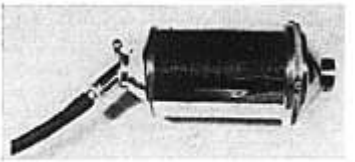

FIG. 2.

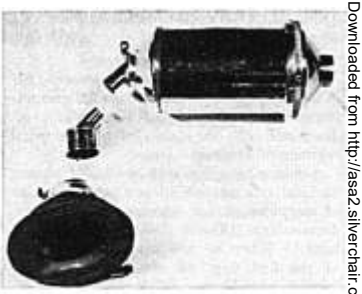

FIG. 3.

mask, the use of this new connection, as shown in figure 4, is preferable to the previous setup (fig. 1) because an extra movable

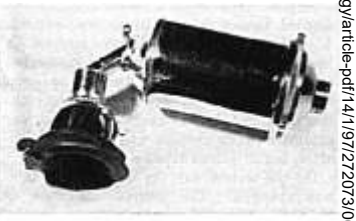

FIG. 4.

joint permits greater flexibility for maintaining the to-and-fro assembly.

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CORRESPONDENCE

To the Editor:

I am writing to you about some of my experiences in esophageal intubation as worthy of inclusion in the section of Anesthesiology, "Current Comment and Case Reports."

There are several tricks related to the pharynx and esophagus by the use of which the anesthesiologist can facilitate the work of the surgeon.

When it becomes necessary in the course of performing an esophagectomy or transthoracic gastrectomy, a Levin tube can be