

Inspiration will open the inspiratory valve on the inhalation side and cause the expiratory valve to close.

Since using this apparatus in children, intratracheal open ether oxygen anesthesia has become simplified. Respiratory effort has been minimized and hypoxia is prevented. The plane of anesthesia is easily maintained with a minimum of anesthetic agent. The incidence of shock as a result of respiratory embarrassment has been decreased. Furthermore, the anesthesiologist is completely removed from the field of operation.

PAUL H. LORHAN, M.D.

PROLONGED ADMINISTRATION OF CYCLOPROPANE DURING ABDOMINAL SURGERY: A CASE REPORT

D. S., a 60-year-old Chinese male, was given cyclopropane for eleven consecutive hours while a gastric resection, splenectomy, partial colectomy, partial pancreatectomy and four intestinal anastomoses were completed. The operation was done through a transthoracic incision. Pre-operative diagnosis was gastric carcinoma and secondary anemia (Hb. 6.5 Gm. before a 500 cc. transfusion on day before operation). The patient was somewhat emaciated but without any recognized disorders of the circulatory, respiratory, genito-urinary or central nervous system.

Morphine sulfate 0.01 Gm. and scopolamine 0.0004 Gm. were given hypodermically at 9:45 a.m. Cyclopropane anesthesia was induced without difficulty at 10:15 a.m. and a nasal endotracheal airway was put in place. The blood pressure immediately before anesthesia was 140 mm. of mercury systolic and 60 mm. of mercury diastolic, the pulse rate 80, and respirations 20 per minute. Operation was started at 10:30 a.m. There was no appreciable change in the patient's condition for the first three hours, during which time he received 1,000 cc. of blood. Shortly thereafter, the blood pressure fell to 80 mm. of mercury systolic and 40 mm. of mercury diastolic, but the pulse and respiratory rates remained constant. Ten minutes later, the pulse rate increased to 100 beats per minute. Another 1,000 cc. blood by transfusion and 200 cc. of saline-glucose

with the technical assistance of Mr. Kyo Ota.

*Department of Anesthesia,
University of Kansas,
School of Medicine,
Kansas City, Kansas*

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solution were given. Within an hour, the blood pressure was improved, 120 mm. mercury systolic and 60 mm. of mercury diastolic, and thereafter remained at levels between this and the preanesthetic level. Another liter of blood was given before operation was completed. The pulse rate was never more than 100. Respirations, which were spontaneous throughout, continued at 20 to 30 per minute. When the incision was closed (9:20 p.m.), the blood pressure was 110 mm. of mercury systolic and 70 mm. of mercury diastolic, pulse rate 90 and respirations 24 per minute. The patient reacted promptly when anesthesia was discontinued and his respiratory tract seemed to be free of secretion. Within an hour, he was awake and rational. There were no definite postanesthetic complications for forty-eight hours. There was a 75 per cent pneumothorax of the left chest. The patient's condition continued satisfactorily until the third postoperative day when his temperature rose to 103 F. and he appeared weak and exhausted. He expired the following day. There were metastatic nodules in the abdomen, a left pneumothorax, emphysema of the left chest wall and very early evidence of pneumonic infection in the left lung.

E. A. ROVENSTINE, M.D.,
*New York University,
College of Medicine,
New York, N. Y.*

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