
"General anesthesia is best administered by an anesthesiologist or by a registered nurse anesthetist. Your credentials committee should examine the qualifications of any physician privileged to administer general anesthesia in your hospital and record their recommendations on his accepted application blank. If the registered nurse anesthetist is not a member of her specialty society, her training and experience should be carefully evaluated to show that the hospital has exercised due care in the selection of individuals doing this important work.

"The occasional administration of general anesthesia by a nurse who is devoting most of her time to the usual care of the patient on the wards or in the rooms is not advisable. The anesthetists or anesthesiologists should be giving anesthesia frequently enough to maintain skill and technique."


"Cardiac arrest has followed the injection of adrenaline during halothane anesthesia on a number of occasions, both in experimental animals and in man. Other disturbances of cardiac rhythm have been detected frequently. . . . In order to elucidate this problem further, 100 patients were studied electrocardiographically, when both halothane and adrenaline were being used. . . .

"In this study a method of anesthesia was employed which is widely used in clinical practice, viz. premedication, intravenous thiopentone induction, followed by maintenance with nitrous oxide, oxygen, and halothane. . . .

"The spontaneous occurrence of arrhythmias was found in 13% of patients during light halothane anesthesia, in spite of adequate ventilation, with high oxygen concentration and in spite of 0.6mg. atropine intramuscularly. Arrhythmias of a type suggesting myocardial irritability followed adrenaline infiltration in 11% of patients."


"A paralyzing dose of suxamethonium when injected rapidly intravenously, almost invariably produces marked muscle fasciculation, followed immediately by profound paralysis. However, the author formed the impression that when used to facilitate endotracheal intubation during the induction of general anesthesia in patients presenting for open heart surgery, a greater number of cases failed to fasciculate than is generally the case. . . .

"In all adult patients presenting for open heart surgery, suxamethonium chloride in a standard dose of
50mg was used to facilitate endotracheal intubation following the induction of general anesthesia with thiopentone sodium. This dose was injected rapidly intravenously into an ante-brachial vein. The subsequent presence or absence of muscle fasciculation was recorded. When present, the quality of the fasciculation was noted as being (a) good to moderate or (b) poor. The time elapsed from injection of suxamethonium to onset of fasciculation was recorded.

"The lesion of mitral incompetence with the possible association of tricuspid incompetence appears to modify the response to the injection of a standard dose of 50mg of suxamethonium, a paralyzing dose in the majority of adults. Of a group of patients with mitral incompetence, one-third failed to show muscle fasciculation following the injection of suxamethonium. Further, in a high proportion of these the relaxation produced for intubation could be classed as inadequate, necessitating a repeat dose.

"The most probable reason for these observations lies in the effect the circulatory dynamics of this lesion have on the manner in terms of time and concentration in which the injected drug reaches the muscle mass."


"Since 1958, several cases have been reported of liver injury following halothane anaesthesia, and it has been claimed that the injury was caused by this anaesthetic. . . . Conflicting data prompted us to investigate if halothane anaesthesia does cause liver injury. Factors investigated include the activity of the liver-specific enzyme ornithine carbamoyl transferase (OCT) in serum before and after anaesthesia. An increase in OCT activity is at present the most sensitive test for acute liver-cell injury . . . halothane anaesthesia was found to induce a rise in OCT. Consequently, the study was extended to include patients receiving ether or spinal anaesthesia.

"The series of patients comprised 14 males and 10 females whose ages ranged from 19 to 62 years. . . . After the anaesthesia, the OCT activity fell initially in all the halothane cases and then rose to a maximum one week after exposure. In 10 of these patients, OCT reached definitely pathological levels. GOT and GPT remained within normal limits. The same enzyme pattern was observed in the patients given ether or spinal anaesthesia. It follows that the liver injury represented by the increase of OCT was caused by the anaesthesia and/or the surgery as such and not just by the halothane."


"The anesthesiologist and the nurse-anesthetist have many close contacts with the surgical and medical patients throughout the hospital, especially in the operating room, recovery room, and intensive care unit. Subsequently they must share in the responsibility of preventing and controlling cross infection. . . .

"It is becoming increasingly apparent that present standards of sterilizing anesthesia equipment are unsatisfactory. At the Massachusetts Eye and Ear Infirmary, since December 1959, the anesthesia equipment
has been sterilized with ethylene oxide. Since sterility must be achieved, the process must accomplish the destruction of all spores. This is assured by the assistance of physical methods consisting of vacuum-pressure, to promote penetration, and of gentle heat, to increase the rate of bactericidal action. To promote a margin of safety, exposure periods should be of adequate length.

"Ethylene oxide sterilization is slow, more expensive than steam, requires special equipment with airtight cabinets, and calls for dilution with Freon or carbon dioxide. Deterioration of latex cuffs and catheters owing to heat is easily overcome by means of a small gas sterilizer for the latex cuffs and catheters, with 100 per cent ethylene oxide at room temperature and exposure for 12 hours. . . . Five years' experience in more than 30,000 cases has shown no allergic reactions or toxic effects from ethylene oxide as a sterilizing agent."


"The incidence of spina bifida cystica with accompanying meningomyelocoele in this country is 2.5 per 1,000 live births according to Record and McKeown. The result will be approximately 2,500 cases of spina bifida cystica in any one year if the present trend in the birth rate continues.

"In this series 100 cases of meningomyelocoele and meningocoele which were operated upon in the immediate neonatal period are reviewed. The average age of the babies at time of operation was 12.5 hours . . . Neonates with meningomyelocoele having paralysis of lower limbs have reduced metabolic activity due to their immobility. This fact, combined with the large surface area in proportion to weight, lack of subcutaneous fat and poor temperature regulating mechanism, render these infants liable to lose heat to the environment rapidly. External warmth is essential . . .

"Routine premedication for all meningomyelocoele cases consists of atropine 0.2mg and Vitamin K1, 1.0mg; both are given intramuscularly thirty to forty minutes preoperatively. In the theatre prior to anaesthesia an assessment of the neurological involvement is made clinically, and by faradic stimulation of the muscle groups innervated at and below the level of the lesion and by direct stimulation of the neural plaque. This muscle assessment rating forms the base line for future assessments during the subsequent progress of the child. . . .

"In our centre the usual practice is to lie the baby on a water blanket, through which warm water circulates from a water bath, thermostatically controlled at 40°C. . . . Because of the position of the defect, the baby must be placed on the operating table in the prone position. This is facilitated by placing polystyrene foam pads, or rolled hand towels under the baby's shoulders and pelvis, thus allowing its chest and abdomen free movement for respiration. The diathermy pad is placed under the chest of the child. A stethoscope is fixed to the back of the chest or over the praecordium when diathermy pads are attached to both forearms.

"It is essential that the endotracheal tube is firmly strapped into place before turning the baby onto its face . . . All neonates are intubated awake . . . Once in position
the babies are allowed to breathe spontaneously through the modification of Ayre's T piece type 2 (a) ... Anaesthesia can usually be maintained by a 50:50 mixture of nitrous oxide and oxygen vaporizing 0.5% halothane. ... It is not unusual for meningomyelocele babies to lose a proportionately large amount of blood during surgical repair ...

"At the start of the surgery, a scalp vein infusion, or, occasionally, an infusion into the vein on the dorsum of the hand is started. ... Although we would prefer to use fresh blood in order to minimize the effect of the high potassium level in stored blood, we have to compromise by using the most recently donated stored blood that is available ...

"The incidence of post-operative chest infection in these babies was low. Only one case in the present series developed bronchopneumonia. The incidence of sepsis at the operative site is approximately 40%. ... The incidence of death in the first three months of life was 22% ... the majority of these deaths being due to septic ventriculitis."


"The anesthesiologist is first of all a physician, and as such is concerned with the same principles which apply to the conduct of any medical practice. ... Since a major portion of his practice is primarily within the hospital, the anesthesiologist is in the peculiar position of requiring materials, equipment and personnel which are probably most economically and efficiently furnished by the hospital. In the operating room, he must coordinate, supervise and teach a wide variety of personnel with various levels of skills and training ...

"The anesthesiologist deals with patients who are under the care of almost every other type of medical specialist, and he must therefore keep abreast of developments in many other fields. ... With current techniques, the stages of anesthesia might possibly be called: "Too light, too deep, and just right." The determination of "just right" requires knowledge, experience and skill on the part of the person administering the anesthesia ...

"The amount of equipment for routine care of patients in the operating room is consistently being expanded and increased. ... Disposable are convenient and safe, but economical only if intensive education is carried on in our hospitals and training programs to keep usage at realistic levels. The work load of the anesthesiologist and the anesthetist is tied to the use of operating room facilities. Underutilization is economically unsound, psychologically depressing, and a source of continuing difficulties between the hospitals and the physicians."


"In view of the complexity of the problem of infusion thrombophlebitis, we felt that it was impossible in one study to take note of too many variables suspected as predisposing factors. Therefore, we focused our attention on certain selected factors in circumstances that were otherwise as controlled as possible. Special attention was paid to the following points: —
I. The onset, degree and duration of thrombophlebitis and their possible correlation with other variables.

II. The incidence of thrombophlebitis after the administration of (a) 2.5 per cent thiopental sodium, (b) 5 per cent thiopental sodium and (c) 10 per cent invert sucrose, with special reference to the role of Intraval and pethidine as additional factors if added to the infusion.

III. The incidence of thrombophlebitis after infusions of varying duration.

IV. The possible role of age, sex, allergy and some other constitutional factors.

"Veins on the back of the hand were used in all the cases. Thrombophlebitis was noted in 259 instances (25 per cent). Though the complication was relatively mild in 88 per cent, it was, in most cases, disturbing to the patient. In 32 per cent the symptoms did not appear until after a week. The average duration of thrombophlebitis was about one month.

"Complication occurred more often after the injection of 5 per cent thiopental than of 2.5 per cent solution, but the incidence in both these groups was considerably lower than after infusions of 10 per cent invert sucrose. . . . The duration of the infusion was of paramount importance; the incidence was more than doubled when the duration was extended from 2 hours up to 8 hours. . . . Female sex, retarded peripheral venous blood flow and pethidine-induced histamine-like reaction seemed to predispose to a higher incidence of thrombophlebitis."
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