

New Instruments and Suggestions

A RECORD CARD FOR THE ANESTHETIST

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Those who administer anesthetics sooner or later find it essential to preserve a fairly comprehensive record of each case. This becomes necessary not alone from a scientific point of view, but also for self protection.

NAME	DATE OF OPERATIONS	No.
AGE	SEX	ADDRESS
NAME AND ADDRESS OF NURSE		
OPERATIONS		
SURGEON		
ASSISTANTS		
UNCONSCIOUSNESS AFTER OPERATION	10 min.	PREVIOUSLY ANAESTHETIZED 1 N, 0
CONDITION OF EYES AFTER OPERATION	OK	CHAR. OF INDUCTION Excit. Moderate
F. TEETH / 124 CYANOSIS, RIGIDITY, JACITATION, MUCOS. VOMITING BEFORE, DURING, AFTER		
ANAE. SUCCESS	S. OK	P. OK A. OK
REMARKS:		
CHARGES:	BILL SENT:	PAID:

Fig. 1.—Front of anesthesia record card.

System Anaesthesia	Close Open						
Apparatus Used							
N 2 O + O	3 bags						
ETHER	3 oz	2 oz			5 oz		
CHLOROFORM							
M & A.	1/4, 1/150 at	10-15 M.					
OXYGEN							
Stimulants							
Respiration	f o f f f f						
C. REFLEX	s d a d a s						
PUPIL	d c c c c d						
PULSE CURVE DURING ANAESTHESIA	180	BEFORE ANAESTHESIA	ANAESTHESIA BEGUN	1ST HR. 20 40 60	2ND HR. 20 40 60	3RD HR. 20 40 60	CONSCIOUSNESS RETURNED
	170	A.M. R.M.	A.M. R.M.				P.M.
	160						
	150						
	140						
	130						
	120						
	110						
	100						
	90						
80							
70							
60							
TOTAL TIME OPERATION		1.30	ANAESTHESIA		2.00		
ANAESTHESIA BEFORE OPERATION		.10					

Fig. 2.—Reverse of anesthesia record card.

It is frequently inconvenient to gather personal data at the time of the operation. To avoid this embarrassment a record card and a self-addressed, stamped envelope may be left with the nurse, who is usually glad to secure the desired information. The accompanying figures illustrate such a card.

The front of the card (Fig. 1) requires but little comment. Char. of Induction:—Excitement absent, moderate, marked. Anaes. Success:—S.—Point of view of the surgeon; P.—of patient; A.—of Anesthetist.

Heads for data which are absent should be crossed out. On the reverse of the card (Fig. 2) attention may be directed to the following points:

System of Anesthesia: Open, closed, pharyngeal, intra-tracheal, intravenous, rectal, etc.

M. & A.: Morphin and atropin.

Respiration: free, obstructed.

C. Reflex: sharp, dull, absent.

Pupil: normal, contracted, dilated.

Most records are squared off for five-minute pulse-readings. To save space twenty-minute divisions are here used. Five-minute readings may be shown by a dot one-fourth way across the space. These cards may be had from the Surgical Narcosis Supply Co., 13 East Fourteenth Street, New York City.

This record is original only in its arrangement. I wish to express my thanks to Dr. E. M. Hawks and Dr. F. Montgomery for their kind suggestions.

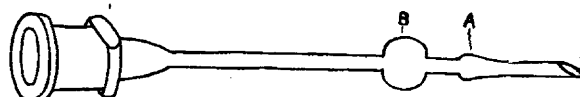
120 Central Park South.

A SELF-RETAINING NEEDLE FOR ADMINISTERING SALVARSAN INTRAVENOUSLY

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Those of us who have been giving salvarsan or other closed venous infusions have each developed a preference for a certain needle, which seems to us best fitted for the work in hand. Some of us swear by the straight needle, others are partial to the curved or one of the many modifications of either, and in all cases the esteem in which we hold our special form of needle is the result of the ease with which we seem able to manipulate it.

Not many physicians can give 120 to 200 c.c. of solution by gravity without experiencing a feeling of impatience at having to hold the needle in a fixed position in fear of its slipping out of the vein. And even when employing the



Self-retaining straight needle; A, conical or retention bulb; B, back-stop.

latest syringe method, in coupling and applying pressure to the piston, we are still obsessed with the constant fear of dislocating the needle point from the lumen of the vein and getting an infiltration into the adjacent tissues. This uncertainty and its consequent complications can be obviated by the use of a self-retaining needle. The object of this paper is to describe the principle on which any of the existing needles may be modified and made self-retaining.

DESCRIPTION OF NEEDLE

On an ordinary needle about one-quarter to five-sixteenths of an inch from the base of the cutting edge is a conical bulb beginning flush with the sides of the needle, becoming larger gradually till its diameter is about one and one-half times that of the needle and its length is one-eighth of an inch. This might be called the "retention-bulb" (A in illustration). A larger globular-shaped bulb, about four times the needle's diameter is placed about one-eighth of an inch distant toward the coupling end. The shape of this "back stop" is of little importance (B in illustration).

My own preference is for the straight needle, and I shall therefore describe my method of operation with this improved needle. I puncture the skin and enter the vein, pushing the needle in as far as the "retention bulb," then make a half turn of the needle on its long axis and push to bury the bulb. The bulb becomes firmly fixed in the skin and the needle becomes stationary and practically immovable. This method of fixing the needle may be compared to the venous infusion cannula in which the dilatation is tied within the vein. Here, however, the skin being elastic permits the entrance of the retention-bulb, which is firmly grasped, but does not enter the vein.

I prefer the straight needle because I like to feel that the possibility of puncturing the posterior wall of the vein is at a minimum, and turning the needle, which you can do only with a straight one, accomplishes this end. When the needle point is presenting in the vein, by turning it, the point, being eccentric, is shifted from the line of punc-