

There are constitutions which will not tolerate the free exhibition of cod-liver oil, and patients of this class are precluded from availing themselves of advantages which might have been of the utmost value to them. Perhaps the quinated oil would agree better with such stomachs.—*Dublin Medical Press*, March 26, 1856.

#### MEDICAL PATHOLOGY AND THERAPEUTICS, AND PRACTICAL MEDICINE.

4. *Asphyxia, its Rationale and its Remedy*.—By MARSHALL HALL, M. D. The term Asphyxia, which ought to be exchanged for apnoea, designates that condition of the animal system which results from the suspension of respiration.

Respiration involves two processes—the inhalation of oxygen, and the exhalation of carbonic acid.

*The remedy* for the suspension of respiration is, on every principle of common sense, the restoration of respiration. This view might be considered, irrespective of physiological inquiry and proof, as self-evident; but that proof is amply supplied by physiology.

Of the two functions suspended, it is certain, from physiological inquiry, that the retention of the carbonic acid is by far the more fatal, and that, in a word, asphyxia is the result of carbonic acid retained in the blood, which becomes, in its excess, a blood-poison.

If this view be correct, it is evident that restored respiration is to the blood-poison in asphyxia what the stomach-pump is to poison in the stomach; and that it is *the* special remedy, the *sine qua non*, in asphyxia.

But this blood-poison is formed with a rapidity proportionate to the circulation, which is, in its turn, proportionate to the temperature. To elevate the temperature, or to accelerate the circulation, *without* having *first* secured the return of respiration, is therefore *not to save*, but in reality *to destroy life!*

Now, let me draw my reader's attention to the *Rules* for treating asphyxia, proposed and practised by the Royal Humane Society. They are as follow:—

“1. Convey the body carefully, with the head and shoulders supported in a raised position, to the nearest house.

“2. Strip the body, and rub it dry; then wrap it in hot blankets, and then place it in a warm bed in a warm chamber free from smoke.

“3. Wipe and cleanse the mouth and nostrils.

“4. In order to restore the natural warmth of the body:—

Move a heated covered warming-pan over the back and spine.

Put bladders or bottles of hot water, or heated bricks, to the pit of the stomach, the arm-pits, between the thighs, and to the soles of the feet. Foment the body with hot flannels.

Rub the body briskly with the hand; do not, however, suspend the use of the other means at the same time; but, if possible, immerse the body in a warm bath at blood heat, or 100 deg. of the thermometer, as this is preferable to the other means for restoring warmth.

“5. Volatile salts or hartshorn to be passed occasionally to and fro under the nostrils.

“6. No more persons to be admitted into the room than is absolutely necessary.”

My first remark on these rules for treating asphyxia is, that “to convey the body to the nearest house,” is doubly wrong. In the first place, *the loss of time* necessary for this purpose is—*loss of life!* on the contrary, not a moment should be lost; the patient should be treated instantly, on the spot, therefore. In the second place, except in very inclement weather, the exposure of the face and thorax to the breeze is an important auxiliary to the special treatment of asphyxia.

But most of all, the various modes of restoring the temperature of the pa-

tient, the warm-bath especially, are objectionable, or more than objectionable; they are at once inappropriate, unphysiological, and deleterious.

If there be a fact well established in physiology, it is that an animal bears the suspension of respiration in proportion, not to the warmth, but, within physiological limits, to the lowness of the temperature, the lower limit being about 60° Fahr. A warm-bath of 100° Fahr. must be injurious.

All other modes of inducing warmth are also injurious, if they divert the attention from *the one remedy* in asphyxia—artificial respiration,—or otherwise interfere with the measures to be adopted with the object of restoring this lost function.

Such, then, are the views which the scientific physician *must* take in regard to the late rules for treating asphyxia promulgated by the Royal Humane Society.

I now proceed to state the measures by which those rules must be replaced.

I revert to a proposition already made: as asphyxia is the result of suspended respiration, the one remedy for the condition so induced is, self-evidently and experimentally, the restoration of respiration.

But there is an impediment to artificial respiration never before pointed out. It is the obstruction of the glottis or the entrance into the windpipe, in the supine position, by the tongue falling backwards, and carrying with it the epiglottis—an event which can only be effectually remedied by adopting *the prone position*.

In this position the tongue falls forward, drawing with it the epiglottis, and leaving the ingress into the windpipe *free*.

But even when the *way* is patent, there remains the question, how is respiration to be effected? The syringe or the bellows may not be at hand, and if they were, the violence used by them is apt to *tear* the delicate tissue of the lungs. The mode proposed by Leroy, of compressing the thorax by means of a bandage, and allowing its expansion by the resilience of the costal cartilages, is proved by experiment to be futile, chiefly, no doubt, from its being attempted in the supine position, with the glottis obstructed.

The one effectual mode of proceeding is this: let the patient be placed in the prone position, the head and neck being preserved in their proper place. The tongue will fall forward, and leave the entrance into the windpipe free. But this is not all, the thorax and abdomen will be *compressed* with a force equal to the weight of the body, and *expiration* will take place. Let the body be now *turned* gently on the side (through rather more than the quarter of a circle), and the pressure on the thorax and abdomen will be removed, and *inspiration*—effectual *inspiration*—will take place! The expiration and inspiration are augmented by timeously applying and removing alternately pressure on the spine and ribs.

Nothing can be more beautiful than this life-giving—(if life *can* be given)—this breathing process.

In one series of experiments, twenty cubic inches of air were *expelled* on placing a corpse in the prone position, and ten cubic inches more by making pressure on the thorax and ribs, the *same* quantities being *inhaled* on removing that pressure, and on rotating the body on its side. But I must give the experiments in detail:—

A subject was laid on the table, and pressure made on the thorax and ribs, so as to imitate the procedure of Leroy. There was no result; a little gurgling was heard in the throat, but *no inspiration* followed. The tongue had fallen backwards, and closed the glottis or aperture into the windpipe! All inspiration was prevented.

Another subject was placed in the *prone* position. The tongue having fallen *forwards*, and the glottis being free, there was the *expiration* of twenty cubic inches of air, a quantity increased by ten cubic inches more on making pressure along the posterior part of the thorax and on the ribs. On removing this pressure, and turning the body through a quarter of a circle or rather more, on the side, the whole of the thirty cubic inches of air were *inspired*!

These manœuvres being repeated, ample respiration was performed!

Nay, there may be a question whether such considerable acts of respiration may not be too much.

It is to be observed, however, that, in this mode of artificial respiration, *no force* is used; the lung therefore is not injured; and that, as the air in the trachea and bronchial tubes undergoes little or no change in quantity, the whole inspired air passes into the air-cells, where the function of respiration is alone performed.

It deserves to be noticed, that in the beginning of this experiment in the prone position, the head had been allowed to hang over the edge of the table: all respiration was frustrated! *Such is the importance of position.*

Reserving the full exposition of this method of *postural respiration*, this *thæopnœa* (from *thæsis*, position), for another occasion, I will conclude by reducing these views into the simplest *Rules* for the treatment of asphyxia.

#### *New Rules for the Treatment of Asphyxia.*

I. Send with all speed for medical aid, for articles of clothing, blankets, &c.

II. Treat the patient on the spot, in the open air, exposing the face and chest freely to the breeze, except in too cold weather.

#### I. *To excite Respiration,*

III. Place the patient gently on the face (to allow any fluids to flow from the mouth).

IV. Then raise the patient into the sitting posture, and endeavour to *excite* respiration,

1. By snuff, hartshorn, &c., applied to the nostrils;
2. By irritating the throat by a feather or the finger;
3. By dashing hot and cold water *alternately* on the face and chest.

If there be no success, lose no time, but

#### II. *To imitate Respiration,*

V. Replace the patient on his face, his arms under his head, that the tongue may fall *forward*, and leave the entrance into the windpipe free, and that any fluids may flow out of the mouth; then

1. Turn the body gradually but completely on the *side*, and a little more, and then again on the face, alternately (to induce *inspiration* and *expiration*);
2. When replaced, apply pressure along the back and ribs, and then remove it (to induce further *expiration* and *inspiration*), and proceed as before;
3. Let these measures be repeated gently, deliberately, but efficiently and perseveringly, *sixteen times* in the minute only;

#### III. *To induce Circulation and Warmth,*

1. *Continuing* these measures, rub all the limbs and the trunk *upwards* with the warm hands, making *firm pressure* energetically;
2. Replace the wet clothes by such other covering, &c., as can be procured.

VI. *Omit the warm-bath until respiration be re-established.*

To recapitulate, I observe that—

1. If there be one fact more self-evident than another, it is that artificial respiration is the *sine quâ non* in the treatment of asphyxia, apnœa, or suspended respiration.

2. If there be one fact more established in physiology than another, it is that within just limits, a *low* temperature conduces to the protraction of life, in cases of suspended respiration, and that a more elevated temperature destroys life. This is the result of the admirable, the incomparable, work of Edwards.

3. Now the *only* mode of inducing efficient *respiration* artificially, at all times and under all circumstances, by the hands alone, is that of the postural manœuvres described in this paper.

This measure *must* be adopted.

4. The *next* measure is, I have stated, to restore the *circulation* and *warmth* by means of pressure firmly and simultaneously applied *in the course of the veins*, therefore *upwards*.

5. And the measure *not to be adopted*, because it tends to extinguish life, is the *warm bath, without* artificial respiration.

This measure *must* be relinquished.

These conclusions are at once the conclusions of common sense and of physiological experiment. On these views human life may, nay, must, sometimes depend.—*Lancet*, April 12, 1856.

5. *On Jugular Venesection in Asphyxia, Anatomically and Experimentally Considered.*—A paper on this subject was read before the Medico-Chirurgical Society of Edinburgh (March 19th, 1856), by Dr. STRUTHERS. The object of the paper, which was illustrated by preparations and drawings of the valves in the cervical veins of the human subject, was to ascertain whether distension of the right side of the heart could be relieved by opening the external jugular vein in the human subject. The experiments of Drs. John Reid, Cormack, and Lonsdale, had satisfactorily shown that, in the lower animals (dogs, cats, and rabbits), the right side of the heart could be thus disgorged so as to restore its action, which had been arrested by a simple mechanical cause, over distension. He considered that the indication of restoring the heart's action by jugular regurgitation, had not received that attention which Dr. Reid's suggestive paper demanded for it. Dr. Struthers described the anatomy of valves which he had found in the cervical veins, as well as those usually alluded to as present in the external jugular. A pair of valves at or within the mouth of the internal jugular vein; a pair in the subclavian vein immediately external to the point of union with the external jugular; a pair at or within the mouth of the external jugular; a second pair in the course of the external jugular, at the upper end of its sinus, or large portion, about  $1\frac{1}{2}$  inch above the clavicle, and various lesser valves at the mouths or within the tributaries of the external jugular. The varieties, and relative position of the two portions of each pair of valves was described, as he had found them in numerous careful examinations. With the view of ascertaining whether regurgitation could take place notwithstanding these valves, Dr. S. performed a series of experiments on the dead subject. A pipe was fixed in the femoral vein, and tepid water thrown freely upwards. The general result was, that the external and other jugular veins very soon became distended, and that when the lancet opening was made, at about an inch above the clavicle, the fluid regurgitated freely. At first a jet came, emptying the distended sinus, and then it continued to flow, never in a jet, but in an active stream across the neck, escaping by the wound with a wriggling motion, evidently due to the obstruction offered by the valve which it had overcome. Care was taken to ascertain that the fluid came by regurgitation, not from above; but, if allowed, it also came freely from above, having ascended by the internal jugular. The introduction of a probe so as to hold aside the guardian valve of the external jugular did not much accelerate the regurgitating flow. When the catheter was introduced, however, the fluid came very freely by it—as freely as from a distended bladder. It is easy to introduce a common male catheter to the vena cava or right auricle, by directing it backwards and inwards, as well as downwards, from the point of venesection. But as soon as the catheter has entered the subclavian vein, the fluid comes as freely as when it is pushed farther. As soon as the point of the catheter is withdrawn into the external jugular, the fluid ceases to come by it. In one subject the fluid could not be made to regurgitate. This was at the time attributed to the circumstance that the cranium had been opened for the removal of the brain, the fluid pouring out by the cranial sinuses; but, on dissection, two pairs of valves were found in the external jugular below the lancet opening, besides the pair above it, as usual. Regurgitation seems to be prevented by two pairs of valves, though one pair may be overcome. In these experiments the veins of the arm did not become distended, and no regurgitation took place from a lancet-opening in the axillary vein, although afterwards it was seen that only two pair of valves had stood in the way, between the heart and the opening. By "pair," Dr. S. meant the two separate portions which act together as one valve. He (Dr. S.) drew the following conclusions: 1. No venesection can be of any use in asphyxia, except in the neck, on the principle of regurgitation; which, how-