Surgical Resurrections

At that time I was little practised in the technique of local anaesthesia for thyroid operations, and thought it fairer to hand the case over to a surgical friend who had had a large experience of local anaesthesia. The patient was accommodated in a private ward some little distance from the theatre, and the decision was made to inject the local anaesthetic before taking her to the operating room. No difficulty was experienced in performing the local infiltration, but when this had been three parts done the patient began to look slightly uncomfortable and complained of difficulty in getting her breath. Discomfort soon became obvious and distress and slight cyanosis developed. Very rapidly the symptoms of asphyxia began to appear and she became unconscious. Seeing that prompt action would need to be taken, I ran to the theatre to warn them to have everything absolutely ready and to bring back a few instruments. I was soon followed by the surgeon himself, who with obvious agitation said that unless something were done at once the patient was lost. He snatched up a scalpel and two or three artery-clips and we both sped back to the bedroom. As we opened the door we were met by the Sister in charge who said that the patient was dead. The porters had lifted her from the bed to the stretcher intending to hurry her to the theatre, but when all evidence of breathing had ceased and no pulse could be felt at the wrist the Sister had made them put the stretcher down on the floor. There was no sign of life apparent when we arrived though naturally no prolonged auscultation of the heart was carried out. I went down on my knees and began to perform artificial respiration, whilst my friend with a celerity which was amazing (and which to this day I remember with envy), also knelt down and with two or three bold and skilful cuts with the knife exposed the thyroid gland and dislocated forward the right lobe which was causing the respiratory obstruction. The whole of this manœuvre only took a few seconds, during which time I was continu-
ing artificial respiratory movements, though with difficulty, as might be imagined. After the tracheal pressure was relieved, however, I could work more easily, and in a minute or two we were relieved to see the colour in the cheeks become more healthy and a palpable pulse came back to the wrist. Then spontaneous breathing movements began and the terrible suspense was over.

The patient was then conveyed to the theatre where the operation was proceeded with. Owing to the temporary failure of the circulation hardly any bleeding had occurred up to this time, though only two artery-clips had been used. The rest of the operation took twenty minutes to perform. During this time the patient showed no sign of consciousness, and she never afterwards had any recollection of the operation. This is the only time that I have ever seen the state of asphyxia play a part in anaesthesia, but the long duration of unconsciousness may be of some interest to physiologists.

Though the first part of the operation in the patient's room was performed without any possibility of preventing contamination of the wound, there was no sepsis and the parts healed by first intention.

The patient made a perfect recovery and, so far as I know, never knew anything of the perils she had undergone. She died two years later of an apoplectic stroke.

It is easy to be wise after the event, and each one will no doubt be able to extract some lessons from this case, but for myself I was extremely thankful that I handed the case over to one who was more experienced, for I might have put down to my inexperience what was really due to the inherent difficulties of the case.

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Surgical Resurrections—III

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