REVERSIBLE FACIAL PARALYSIS

PARALYSE FACIALE REVERSIBLE APRES GONFLEMENT TRAUMATIQUE DE LA REGION PAROTIDienne AU COURS D'UNE OPERATION

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Consécutivement à une pneumonectomie en décubitus, un garçon de dix ans développait un gonflement du côté droit du visage, accompagné d'une paralysie faciale. On croit qu'une traumatisme par pression au cours de l'opération en est responsable. La nature du gonflement n'a pas été déterminée. La paralysie faciale disparaissait dans la semaine.

REVERSIBLE FACIALISLÄHMGUNG IM ANSCHLUSS AN EINE TRAUMATISCHE, WÄHREND EINER OPERATION AUFGETRE-TENE SCHWELLUNG IM PAROTISBEREICH: EINE FALLBESCHREIBUNG

ZUSAMMENFASSUNG

Im Anschluß an eine Pneumonectomie in Bauchlage bei einem zehnjährigen Jungen trat auf der rechten Seite des Gesichtes eine Schwellung auf, die mit einer Facialislähmung verbunden war. Es wird die Ansicht vertreten, daß eine Druckverletzung während der Operation dafür verantwortlich zu machen ist. Die Natur der Schwellung wurde nie bestimmt. Die Facialislähmung verschwand innerhalb einer Woche.

CORRESPONDENCE

INFERIOR VENA CAVAL OCCLUSION IN LATE PREGNANCY AND ITS IMPORTANCE IN ANAESTHESIA

Sir,—Dr. Scott (Brit. J. Anaesth., 1968, 40, 120) states that vasopressors should be avoided following spinal and epidural anaesthesia in the pregnant patient at term. The reason given is the distinct possibility of hypertension occurring following delivery. He suggests that when symptoms of acute hypotension develop "such as faintness, nausea and vomiting" the patient should be "encouraged with the assurance that these symptoms will quickly disappear once the baby is delivered". In my experience such encouragement has never alleviated the symptoms. While recognizing the danger of hypertension in these circumstances, may I describe a technique which I feel allows one to "have one's cake and eat it too".

An intravenous infusion is started prior to the spinal or epidural injection. A second solution containing 20 mg metaraminol (Aramine) in 500 ml is prepared and connected "side saddle" to the original infusion. At the first sign of hypotension after induction of anaesthesia the metaraminol is started. The rate of infusion is determined by the response of the blood pressure. It is usually possible to stop the metaraminol some time prior to the delivery of the baby but in any event the action of this agent, given this way, is so evanescent that post-delivery effects are not seen.

I have used this technique for a large number of Caesarean sections in the last five years and have never seen the metaraminol fail to maintain an adequate blood pressure nor have there been any hypertensive episodes after delivery. Nausea is controlled within moments and the obstetrician does not have to operate on a heaving abdomen. It should perhaps be pointed out that the obstetricians with whom I work all refrain from the use of intravenous ergot preparations in the presence of spinal or epidural anaesthesia, a factor which I am certain plays an important part in the avoidance of post-delivery hypotension.

BERNARD WOLFSON

Pittsburgh

Sir,—Thank you for showing me the letter from Dr. B. Wolfson. The administration of metaraminol in the way suggested will certainly reverse hypotension and relieve symptoms without running the risks of post-delivery hypertension. It should be clearly understood, however, that reversal of hypotension is not the same thing as a return of the circulation to normal.

There is considerable evidence that vasoconstrictors often have little beneficial effect upon cardiac output and may even reduce it, possibly explaining the experimental results of those workers, who found these drugs caused neonatal depression.

The main cause for circulatory embarrassment during Caesarean section is inferior vena caval occlusion which will not be corrected until the baby is delivered, and thus speedy delivery should be carried out. This should seldom take longer than 5 minutes with a competent obstetrician. Elevation of the blood pressure with a vasopressor relieves symptoms of hypotension, but may lead to a false sense of security that all is well with the circulation when in fact cardiac output is dangerously low. It is better to treat a mechanical occlusion mechanically (i.e. by delivery) rather than pharmacologically.

D. B. SCOTT

Edinburgh

THE USE OF PETHIDINE AND MORPHINE IN THE PRESENCE OF MONOA MINE OXIDASE INHIBITORS

Sir,—I believe—and hope—that I am not numbered among the mealy-mouthed. I favour the enthusiastic injection of the scientific spirit into clinical medicine, yet I must confess that Dr. Evans-Prosser's article in the April issue (Brit. J. Anaesth., 1968, 40, 279) caused me some unease. The subjects of the investigation were psychiatric in-patients. In common, doubtless, with the majority of your readers, I am totally ignorant of the factors which govern the admission of patients to psychiatric wards, and of the medical conditions which pertain in the departments concerned. However, one surely must assume, unless told otherwise, that these subjects were considered—by virtue of their degree of mental instability—to be unfit to carry on an existence outside of hospital and to receive out-patient therapy. In addition, all the subjects investigated had for several weeks received twice-daily doses of at least one tranquilizer, which presumably interfered to some extent with their critical faculties and their ability to reject the investigator's invitation. With this in mind, it seems to me that Dr. Evans-Prosser dismissed in rather cavalier fashion the question of consent with the note that "The patients were all considered capable of understanding the nature of the trial and their part in it. Only one declined."

I do not wish to be offensive in this matter, but we are all only too well aware of the campaigns which are being mounted against research in the context of
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