DEATHS ON THE TABLE IN GENERAL PRACTICE

BY

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The harrowing experience of a death on the operating table comes sooner or later to every anaesthetist, and it is to be regretted that the subject is not more freely and frankly discussed in medical literature and at medical meetings.

We must admit, I suppose, that anaesthetic deaths are avoidable and should be avoided. In the *British Journal of Anaesthesia* (1937, 14, 55) Dr. H. Grant-White discusses how some deaths may be avoided, and he stresses particularly the need for modification in the method of inquiry into anaesthetic deaths, which would result in the collection of valuable information. The same journal in an editorial (1938, 15, 86) suggests that the cure for anaesthetic fatalities is education and more education. We cannot, however, obtain this education unless anaesthetists will tell us about their own cases.

The following cases occurred in my own practice, and their publication will, I hope, lead to the recording of similar fatalities by others.

Illustrative Cases

Case 1.—A woman aged 32, admitted to hospital with a diagnosis of ruptured ectopic gestation. This patient was extremely ill and almost pulseless. Premedication: atropine, grain 1/100. Induction: gas-oxygen-ether; a nasal tube was then introduced into the trachea and the anaesthetic was continued with gas-and-oxygen. When the patient was being got ready for operation there was some little trouble in adjusting the table, and I assisted in getting it put right. Just at this moment the patient stopped breathing, and although oxygen was administered through the endotracheal tube and cardiac massage was adopted she died.

Case 2.—A man aged 75. Operation: removal of prostate. No premedication. I was not present in the theatre at first, because the surgeon intended to give a spinal anaesthetic himself. The patient, however, had a very marked osteo-arthritis of the spine and the needle could not be introduced. I was sent for in a hurry to administer an inhalation anaesthetic. Gas-oxygen-ether was the anaesthetic used, and all went well until the surgeon had almost removed the prostate, when the patient stopped breathing. An attempt was made to give artificial respiration, but the chest wall was absolutely rigid and artificial respiration had no effect. An endotracheal tube was introduced and oxygen given under pressure. The patient's colour did not improve, and as no pulse rate could be found cardiac massage was undertaken. After the second "squeeze" of the heart this started to beat again, and the patient's condition improved and respiration was re-established. The patient died twenty-four hours later without having regained consciousness. Post-mortem examination showed minute haemorrhages on the surface of the brain.

Case 3.—Child aged 10 with a badly crushed foot, in which gas gangrene had developed. The child was terribly ill, but at the parents' urgent request it was decided to amputate. Premedication: morphine and atropine. Anaesthetic: gas-and-oxygen. During the operation the patient's condition became worse and worse, and just as it was completed the child died.

Case 4.—Child aged 6. Intestinal obstruction—general peritonitis and appendicitis. Premedication: atropine. Anaesthetic: gas-oxygen-vinesthene. All went well until the surgeon started to stitch up the peritoneum, when the patient developed violent ether convulsions. Oxygen was administered and the patient's condition gradually improved, the convulsions passing off in about ten minutes. After the operation was completed oxygen was administered for some little time, as I feared that the convulsions might start again when the patient returned to the ward. After half an hour, as the patient's colour was good and

the general condition fair, I told the porter to fetch the trolley to take the child back to the ward. Just as the trolley was brought alongside the table the patient died.

Case 5.—Child aged 4. Acute peritonitis and appendicitis. Anaesthetic: gas-oxygen-vinesthene. All went well until the surgeon introduced his hand into the abdomen. Immediately there was a violent regurgitant vomiting of the stomach contents: it was just like pouring water out of a jug. I tried to mop out the mouth and introduce an endotracheal tube, but failed completely. The patient died in a few minutes.

Case 6.—Man aged 85. Acute retention of urine. An emergency operation for the introduction of a suprapubic tube. The patient's condition was not good and I was asked to give only gas-and-oxygen. He had, however, received no premedication and the operation presented unexpected difficulties. I pushed the gas a little too far; the patient became anoxaemic and stopped breathing. An endotracheal tube was quickly introduced and oxygen given under pressure. The patient started to breathe again and the operation was completed, but he died six hours later.

Case 7.—Girl aged 15. Acute appendicitis, first seen at 3 p.m. She was the child of most difficult parents, who insisted that she must not be removed to the nursing home until the surgeon arrived. The nursing home was next door. It was impressed on the parents that no food of any kind must be given. About five o'clock, however, the girl felt better and demanded a meal. She was given a large feed of sausages, of which we were not informed. The operation took place at seven o'clock and proved to be one of exceptional difficulty. Endotracheal gas-oxygen-ether was the anaesthetic administered. Just as the surgeon was about to stitch up the peritoneum ether convulsions developed. These, however, passed off in about ten minutes, and the patient's condition improved. The endotracheal tube was withdrawn and the patient was returned to bed. She died early the next morning without recovering consciousness.

Case 8.—Boy aged 15. Multiple injuries from road accident. Anaesthetic: gas-oxygen-vinesthene. It took a long time to repair the many injuries, and the boy's condition became worse and worse. When the operation was completed he was almost pulseless, and died twenty minutes afterwards.

Discussion

Now, I think something may be learned from this series of cases. Some of these deaths might have been avoided.

In Case 1 I should never for a moment have taken my eyes off the patient. In Case 2 I think I hurried the induction too much and should have passed the endotracheal tube immediately breathing stopped instead of trying to do artificial respiration on an impossible subject. Cases 3, 4, and 8 were beyond my powers to save. In Case 5 death should have been avoided. I should have been ready for the vomiting and should have passed the endotracheal tube and washed out the stomach in the ante-room before the patient went on to the table.

Case 6 was an example of how dangerous it is to try to do too much with gas-and-oxygen. Had a little ether or vinesthene been added to these gases a successful result to the operation might have been expected. The cause of death in Case 7 was really, I think, the sausages, and is an example of what may happen when a patient is left in the care of untrained people for some hours before operation.

To ensure the proper after-care of children who have received in-patient treatment for injuries due to enemy action, the Ministry of Health is arranging for E.M.S. hospitals to notify the Medical Branch of the Board of Education (at Branksome Dene Hotel, Bournemouth) whenever it is proposed to discharge a child casualty. The Board of Education will then get in touch with the local or welfare authorities in the area to which the child is to be sent. Circular 2427 of the Ministry of Health prescribes the form of notification, and asks hospital authorities to bring these arrangements to the notice of medical superintendents and other medical officers concerned.