EDITORIAL : VAN DIE REDAKSIE

ENDOTRACHEAL ANAESTHESIA: OBSCURUM PER OBSCURIUS

Some months ago the lay press reported the sudden death of a well-known personality which was caused by an abnormal communication between the nose and the extradural space. It appears that the anaesthetist inflated his apnoeic patient before laryngeal intubation, and death occurred almost immediately from herniation of the brain. More recently an established teacher of anaesthesia reported a number of iatrogenic catastrophies and concluded, rightly or wrongly, that something is amiss in modern anaesthetic practice.[1]

Anaesthetist-apologists responded with great vigour, and this correspondence was welcomed because it was felt that in encouraging dignified polemics on a scientific level, which might have led us *not* 'to come out by the same door as in (we) went', a service was being rendered to the profession. However, the tone of some of the correspondence was not altogether satisfactory in that the degree of dispassionate enquiry that was expected had not been achieved. To be sure, revealing and valid arguments were used by some correspondents; these contributed towards achieving the aim of objective discussion of an important and controversial subject. But examples of *argumentum ad hominem*, in which blows were directed against the *man* instead of his *argument*, also abounded, and this reflects the kind of approach to an academic and clinical problem which we can ill afford to borrow from some of our less discerning politician-friends.

Experienced practitioners in South Africa often claim that their patients for caesarean section, for example, did better with 'vinethine' and ether on an open mask than nowadays with pentothal and muscle relaxants. It must be remembered that in our country most anaesthetics are given, of necessity, not by the specialist, but by the general practitioner — as Dr. Jones[2] himself pointed out in this *Journal*. This is by no means to be construed as a particularly evil thing. France, for example, is in this respect much worse off than we are, but it does mean that the modern techniques described in the specialist journals need to be adapted to local conditions. Thus, laryngeal intubation is clearly contraindicated if facilities are not available for inflation of the lungs with oxygen, or where the anaesthetist has not been instructed in the technique. As a corollary, it is equally imperative to desist from the use of muscle relaxants if the technique of laryngeal intubation has not been thoroughly mastered.

Technically there are three manoeuvres an anaesthetist must master completely before he can administer a safe anaesthetic: the intravenous, endotracheal, and 'spinal' techniques. Provided he takes some interest in the administration of anaesthetics to surgical patients, especially during his compulsory year in hospital practice, there is no reason why the general practitioner need have any fear of practising anaesthesia, particularly in the rural areas of South Africa; often enough he has no option anyway. But he will do well to heed the advice of people like Dr. Jones, who have made a special study of the frequently invidious position of the general-practitioner-anaesthetist. For his part it behoves the specialist to consider the needs of our population in the light of *available* anaesthetists, rather than deploring the slightest deviation from the high present-day specialist standards in clearly sincere attempts to cope realistically with the great shortage of specialist anaesthetists — a problem that is certainly not going to be solved in the near future. Nowhere is the precept to do no harm more important than in anaesthesia; and while this is usually 'terribly simple', it can so easily (at least occasionally) become 'simply terrible'.

Any attempt to mitigate against such iatrogenic disaster clearly merits the serious attention of all concerned. And if the lay press abuses its access to such writings, let us remind ourselves that we, too, have a duty to report cases like those mentioned in the first paragraph of this article, rather than to leave to laymen the reporting of cases. This can only help to dispel obscurity which is in danger of being made more obscure by controversy and negative criticism.

1. Jones, C. S. (1961): S. Afr. Med. J., **35**, 421.
2. *Idem* (1959): *Ibid.*, **33**, 1036.

VAGINALE ONDERSOEK TEN TYDE VAN SWANGERSKAPSBESPREKING

Dit lyk of daar 'n mate van aarseling of traagheid by geneeshere is om 'n swanger vrou vaginaal te ondersoek by die eerste — en dus die beste — geleentheid, nl. die heel eerste swangerskapsbesoek. Nog veel erger — sommige vrouens word nooit vaginaal ondersoek op enige tydstip voor of selfs met kraam nie. Veral is die eersgenoemde versuim sterk af te keur.

Die meeste vrouens kom bespreek die reëlings, ens. vir hul verlossings waarskynlik eers nadat hulle al drie maande lank swanger is, d.w.s. nadat die gevaarlikste miskraamtyd verby is. Dit is buitendien erg te betwyfel of oordeelkundige en versigtige spekulum- en vaginale ondersoeke ooit miskraam veroorsaak. Indien in 'n besondere geval iets van hierdie aard vermoed mag word, kan die ondersoek uitgestel word tot na die derde maand, maar nie langer nie. Daar is dus by verreweg die grootste gros van pasiënte geen werklike kontraindikasie vir hierdie soort ondersoek nie. En daar is veelvuldige goeie redes waarom so 'n ondersoek onderneem behoort te word, want daar mag tog infektiewe of ander toestande van die vulva,

serviks, vagina, uterus, of adnekse wees; en hoe kan die dokter daarvan weet as hy nie hierdie organe sistematies ondersoek nie?

Die vulva mag tekens toon van irritasie — iets wat dikwels saamhang met 'n moniliase-vaginitis — 'n vry algemene swangerskapstoestand wat ontsettend lastig kan wees vir die pasiënt. Ander velletsels mag ook aanwesig wees, asook tekens van ander vorms van vaginitis of aangebore vaginale siste of bande van embriologiese oorsprong. Die serviks mag gedupliseerd wees, wat seldsaam is, of dit mag 'n erosie toon, wat 'n ontstellende voorkoms mag hê vir diegene wat hulself nie gewoond maak aan die swanger serviks en sy voorkoms nie. Dit is veilig om biopsies te neem in swangerskap, met die regte tegniek; of om Papanicolaou-smere te neem (hoewel die histologiese vertolkings moeilik mag wees). Daar word beraam dat servikale karsinoom 'n voorkoms van ongeveer 1 tot 2 in 4,000 gevalle het met swangerskap. Dit is dus vanselfsprekend dat hoe gouer dit gevind word, hoe beter in alle opsigte. By geleentheid mag daar ook 'n inkompotente os so raakgeloop word, en tydige terapie kan dan ingestel word.

Die uterus mag in die vroeë maande verkeerd lê, nl. in retroversie. Dit is op sigself van geen betekenis nie, maar die uterus behoort op drie maande abdominaal te wees anders moet gewaak word teen inkarserasie met moontlike uretraversperring. Ook mag die orgaan groter of kleiner as die verwagting op sekere datums wees, en gevolglik kan tweeling-swangerskap, mola, of intra-uterine dood vermoed word, of fibroïdes kan gevind word, wat soms later in die swangerskap degenereer en dan groot diagnostiese probleme kan skep.

Ten slotte mag daar gewasse of groeisels van die ovaria wees. Daar moet onthou word dat hierdie soort abnormaliteit 'n besondere neiging het tot steeldraaiing in swangerskap — 'n toestand wat kan presenteer as 'n akute buiktoestand en wat verwante diagnostiese en terapeutiese probleme kan oplewer. 'n Verdagte mola kan bevestig word deur die gepaardgaande teka lutein-siste en daar mag selfs 'n korpus luteum-sis wees wat sal neig om in die vierde maand te kwyn. Dit word algemeen beskou as raadsaam om chirurgie, waar moontlik, uit te stel tot na die derde maand.

Daar bestaan dus goeie en genoegsame redes waarom 'n swanger vrou sover as moontlik grondig en omvattend ondersoek moet word met die eerste of wel besprekingsbesoek. Die ondersoek moet 'n sorgvuldige vaginale en spekulumondersoek insluit. Om vooraf kennis te dra van moontlike oorsake van latere komplikasies beteken tog dat die helfte van die stryd gewonne is as hierdie komplikasies hul verskyning maak.