

## DEFIBRILLATION OF HEART IN GENERAL PRACTICE

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The writer, prompted by the recent accounts of resuscitation of fibrillating hearts due to coronary thrombosis by thoracotomy and cardiac massage in hospital practice, enquired of a cardiac surgeon what action a general practitioner should take in such circumstances.

The surgeon replied that the least that should be done is to thump the patient as hard as possible in the centre of the chest, which action in favourable circumstances might produce defibrillation and restart the circulation.

The account below is of the first attempt by the writer of this procedure which seemed to produce partial success. The patient was a man of 47, who had suffered chest pain for a few weeks but had not consulted a doctor. While interior decorating he suddenly suffered severe chest pain radiating into neck and back. The writer found him lying in the room on the floor, restless, shocked, with cold extremities, and blood pressure of 90/50 and a slow pulse of about 50—60/minute. Morphia gr.  $\frac{1}{4}$  was administered subcutaneously and the ambulance sent for to transfer him to hospital. While waiting for this, the patient insisted on having an artificial leg removed and against better judgement the wife and writer began to unfasten the straps. Suddenly the patient dropped back flaccid in coma with intermittent gasping respirations, and steadily widening pupils. No pulse could be felt, and the writer was convinced that there had been cessation of the cerebral circulation due to cardiac arrest through ventricular fibrillation, in the usual manner.

No more than 10—15 seconds were allowed to elapse before heavy thumping of the chest with the flat of the hand was resorted to. This was done three times with intervals of two or three seconds. It was then noticed that the respirations had altered in character and had become quicker and less gasping, and most striking of all the pupils, which were in paralysis, immediately began to contract down again to their normal size. The patient regained consciousness about thirty seconds later and agreed when asked if he had "fainted." The pulse however was never again felt.

Thereafter the patient unfortunately showed steadily worsening signs of acute heart failure, with increasing dyspnoea, marked cyanosis and engorgement of neck veins, onset of coma and death about ten minutes later.

Even though finally this effort was unavailing, the writer has

now confidence that the method is capable of defibrillating the heart in coronary thrombosis, and because of the frequency with which the general practitioner is faced with this situation and the ease of application of the method recommends it to be kept in mind by others.

Since the occurrence of this case the methods of external cardiac massage have become more standardized and refined, but it is felt the case may still have some interest.

## THE TREATMENT OF FIRST AND SECOND DEGREE BURNS

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The theme of this communication is that blisters are a preventable complication of burns. In the treatment of first and second degree burns, it is possible by anticipating the histamine reaction to prevent it, and so to prevent the consequences of a burn after it has been sustained.

This paper is not primarily concerned with third and fourth degree burns, in which there is actual coagulation or charring of tissues at the instant of burning.

The observation upon which this paper is based was made by me over 10 years ago, when a patient burnt herself on the cast iron handle of a grilling pan which she removed from the roasting oven with her bare hand. I was in the house at the time, and saw the burn within half a minute.

When I examined her hand, the shape of the hot handle was branded across her fingers and the distal part of the palm of her hand. The skin was white and shiny. With an instinctive impulse to prevent blisters from lifting, I immediately applied a tight cold water bandage to each finger individually and to the palm of her hand, with a pressure pad in the latter area. I used a cold water bandage, hoping that the cold would relieve the pain, which it did. I instructed the patient to wet the bandages repeatedly under the cold water tap—the indication for doing so being if she felt pain or the bandage got dry.

On removing the bandages about 2 hours later, I was very impressed to find there were no blisters at all. The skin was still white where it had been burnt, but there was no red reaction around the area of the burn. Cold water bandages were reapplied firmly, with the same instructions to keep them wet with cold water. The patient was only to do this at night if pain woke her. In fact, the