

# Letters to the CSA

January 18, 2007

To the Editor:

It is interesting that the precordial monaural stethoscope, with which I became acquainted in 1959, still generates correspondence. As you know, I played a part in its propagation. Over the years I became close friends with Ralph and Doris Burdick who manufactured these devices at Royale Laboratories. When I was Chief of Anesthesiology at the Naval Medical Center, San Diego, all my residents and staff used the device as I did when I was a resident at the same institution.



At first Doris came down to make our earmolds, but then both in the Navy and later at Kaiser Permanente, she sent me the materials and entrusted this assignment to me. I made scores of these molds. Doris always said she could recognize a “Clyde Jones” mold, for it ventured farther into the external auditory canal than those made by the Burdicks. My wife, on hearing this, averred that this was entirely consistent with my personality as an obsessive-compulsive overachiever. Guilty as charged, I guess!

Cordially,

Clyde W. Jones, M.D.

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February 2006

To myself (the editor) and others of my chronological vintage:

Due to lack of space in our last issue, I failed to add my personal commentary to the outstanding Guedel article by Matthew Mazurek, M.D., on the pivotal role played by Chauncey Leake, Ph.D., in the development of divinyl oxide (more commonly referred to as vinyl ether and Vinethene) as an anesthesia drug. Dr. Leake did not know it, but this fellow Princeton alumnus (43 years later) did have the opportunity to use Vinethene as a resident at Boston Children’s Hospital as late as 1966. I used it with an open drop technique as a preliminary inhalational induction anesthetic that facilitated a smooth transition to ethyl ether in children having tonsillectomies by the occasional surgeon who would demand using an ether hook (no intubation) for maintenance of anesthesia. Vinethene dramatically reduced—or even eliminated—the stress-laden (for both patient and anesthesiologist) second

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stage of induction normally encountered with open drop ethyl ether. This was attributed to its physical and physiological properties that were antithetical to the less desirable ones of ethyl ether, as it was not irritating to the respiratory tract, rapidly inducing unconsciousness within one to two minutes, usually without any excitement phase, coughing or laryngospasm. As an impressionable and, indeed, impressed young resident, I asked why not continue with Vinethene, or even why not use it in place of ethyl ether for other surgeries. I was sternly informed that this flammable (as was ethyl ether) agent was not safe for use longer than that of a short induction because it was a hepatotoxin (and possibly nephrotoxic and epileptogenic). Whether this was actually the case in humans likely never will be known.

As a historical addendum, I also was the last holdout on the Stanford faculty to use ethyl ether for teaching inhalational induction (airway management) of anesthesia, finally succumbing to its ban in the operating room around 1970. My residents and surgical interns (yes, they rotated through anesthesia at that time) gained a healthy respect for the “art” of an ethyl ether induction by mask (unaided by thiopental). After ether’s ban, I then mimicked teaching an ether induction by employing mask inductions with another highly soluble and somewhat irritating inhalational anesthetic, methoxyflurane. However, when Richard Mazze and I confirmed methoxyflurane’s nephrotoxic properties that initially had been described in 1965 by Crandall at the White River Junction, Vermont Veterans Administration Hospital (and later verified in 1969 by Ralph Epstein, M.D., and me in a small series of patients having extensive cancer surgery at the National Institutes of Health), I thought it prudent to avoid its further deployment, even for a short teaching exercise.

Stephen Jackson, M.D., Editor

*[I want to thank Patrick Sim and Karen Bieterman of the Wood Library Museum for their assistance, especially in providing information on Vinethene from the fifth edition of John Adriani’s The Pharmacology of Anesthetic Drugs (1970).]*

**Editor’s Note:** It should be noted that the letters published in this section represent the opinions of the individual authors, and no inference should be made as to the opinion of the California Society of Anesthesiologists or the editor. The views expressed here are not official policy of the CSA, and a letter’s publication does not imply agreement or disagreement with the author. We are attempting to provide the membership with a forum to express their thoughts to other California anesthesiologists. We also make every attempt to publish the letters in their entirety and just as we receive them. Insofar as possible, related or opposing views will be published. If a letter deserves a reply, its publication may be delayed until the companion letter is available. Please remember, we do have deadlines and space limitations—thus, the publication of your letter may be delayed to the next issue for these reasons.