INFLUENZAL PNEUMONIA: 
THE INTRAVENOUS INJECTION OF HYDROGEN PEROXIDE.

By T. H. OLIVER, M.A., B.CH. CANTAB., M.D. ... it is not easy to say. It is difficult to believe, however, that so small a quantity of oxygen as is contained in

in the solution of hydrogen peroxide had, in the presence of a catalyst (copper), a remarkable oxidising power on morphia. Further investigation, as yet unpublished, showed that many other substances were similarly oxidised by this solution, the power of which appeared to depend primarily on the formation of nascent oxygen.

We thought that might be made of this reaction if the H₂O₂ were given intravenously, in this instance employing the well-known catalytic powers of hemoglobin as a substitute for the copper, and we hoped thereby, not only to supply oxygen to the tissues with greater rapidity than by the ordinary methods, but also to render the circulating toxins inert by oxidation. The obvious danger was gas-embolism, against which most text-books warn those using H₂O₂ even to wash out serous cavities. We believed, however, in the first place, that pure oxygen, if given sufficiently slowly, would be absorbed before any embolic symptoms developed, and secondly, that the air-embolism known to surgery is really a misnomer for nitrogen embolism.

Effect on Patients.

The first case was an Indian with broncho-pneumonia of influenzal origin and intensely toxemic. He had been delirious for two days previously and 24 hours later had the usual symptoms as a result of lysis of the broncho-pneumonia. This produced a faintly effervescing solution. The median cephalic vein was exposed by open dissection, and the solution infused through a glass cannula attached to a Rogers cholera apparatus.

The solution was infused very slowly, a complete stop being made for half a minute in every four. Small bubbles were allowed to enter the vein unchecked, but if a large accumulation of oxygen appeared in the cannula the transfusion was checked for about a minute until the vein had gradually entered the vein. The whole transfusion lasted for 15 minutes. The patient showed no signs of discomfort until towards the end of the operation, when he became slightly restless. This, however, passed off in a few minutes, and there were no other untoward symptoms except a moderate rigor which occurred two hours later. After the rigor the temperature, which had been 101°F, fell to normal and remained so for 36 hours, when it again rose to 101°F. The latter rise was not accompanied by toxic symptoms, and the temperature gradually fell to normal in the course of the next ten days. The change in the mental condition was remarkable, the patient, who previously had had to be tied in bed owing to delirium, was within six hours of the injection sitting up and asking for food; he slept well the next night and from that time improved in every way, eventually being invalided to India as a walking case three weeks later.

Encouraged by the apparent success in this case, we tried the method on 24 others—cases of influenzal pneumonia—selecting always those whose condition was apparently hopeless. Of the total of 25 cases, 13 recovered and 12 died, a mortality of 48 per cent. Of the 12 who died, 9 showed no visible effect for either good or ill. In 3 there was a temporary improvement. One case only died within 24 hours of the infusion, during a rigor. One of the cases had four Jingoes of the interval of three to five days without any sign of gas embolism, nor did we find any signs of such embolism post mortem. Of the 13 who recovered, 10 were delirious at the time of infusion and had to be held down in bed. Three were comatose from toxemia.

The average respiration-rate before the operation was 45 per minute, the greatest being 60 and the least 28. Within 24 hours of the infusion the average rate was 31.5, the greatest fall being from 108 to 30. The noticed decrease, however, was a stimulating and deepening of the respiration and a great lessening of the discomfort. The average pulse-rate before infusion was 118. 24 hours later the average was 98.

The temperature in this epidemic was, apart from complications such as malaria or effect of heat, rarely high and usually 101°–103°F. In all cases but one the injection was followed by a rigor, after which (except in two of the cases) the temperature fell to normal. Of the two exceptions one remained with the same temperature as before, the other fell from 102°F to 100°F. The afebrile period lasted usually for 18–36 hours, after which the temperature again rose to 99°–101°F, and fell by lysis in 4–7 days.

At this juncture we would point out that the occurrence of a rigor or a fall by crisis is exceeding rare in typhoid-pneumonia in cases of pneumonia. Neither of us remember such observations in our experience of 31 years among British and Indian troops. As regards the toxemia, we believe that the frequent occurrence of a rigor and a complete or partial crisis, combined with a rapid improvement in the patient's general and mental condition, indicated that this was overcome in many instances. Whether this was by merely supplying oxygen to them or the procedure of the infusion of the circulating toxins took place, it is not easy to say. It is difficult to believe, however, that so small a quantity of oxygen as is contained in
Charts of Four Cases in which Hydrogen Peroxide
was given Intravenously.

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An arrow denotes an injection. R = rigor. The first case ended fatally, the others recovered.

Anoxaemia and embolism are the risks of intravenous injections.

2 oz. of H₂O₂ could produce these effects other than by its nascent oxygen, and this view is supported by a trial we made in a case of anoxaemia arising from suppurating inguinal glands in which there was no question of anoxaemia. Here the general improvement which so rapidly took place could only be ascribed to direct oxidation.

The accompanying four charts will give some idea of the reactions obtained in one fatal and three recoveries; in the first it will be seen that four injections were given, the first two of which produced a rigor and temporary improvement. In the second two injections were given, each producing a rigor and some improvement both in pulse and respiration rate. In the third and fourth the injection was followed almost immediately by a rigor and subsequently by a crisis. In all these cases there was marked slowing of the respiration-rate after the injection.

Technique.

A strength of 2 oz. H₂O₂ in 8 oz. of normal saline was usually used. In one case 3 oz. H₂O₂ was used without any ill-effect. Fifteen minutes was allowed for transfusion and this was checked temporarily every four minutes, or whenever large bubbles of oxygen appeared in the cannula, or if the patient became at all restless. Small bubbles entering the vein did not appear to do any harm. In one case the patient struggled so violently in his delirium that the cannula slipped out and the distal ligature came off. On pressing the vein above two distinct streams could be seen to issue from the wound, the one above bright red and frothing, the other deep blue.

The epidemic ceased almost as suddenly as it had begun, so we were unable to try the method on earlier cases or to give a more extensive trial to repeated injections.

Conclusions.

From our experience we conclude that—
1. H₂O₂ can be given intravenously without gas embolism being produced.
2. The anoxaemia is often markedly benefited.
3. The toxemia appears to be overcome in many cases.
4. The mortality (48 per cent.) compares very favourably with the 80 per cent. in similar cases not so treated, and more so when it is remembered that we only treated the most severe and apparently hopeless.

ANÆSTHESIA IN THROAT AND NOSE OPERATIONS.

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The author pointed out that operations upon the ear, nose, and throat are not generally serious in themselves, and that it is, therefore, of primary importance that the technique employed should be as free from risk as possible. After dwelling on the risks of chloroform and mixtures containing it, and the comparative safety of ether, Mr. Rood advanced the following arguments in support of his contention that "ether is the proper anaesthetic for operations upon the nose and throat."

The Degrees of Anaesthesia.

It will be necessary to speak of two degrees of anaesthesia—deep and light. I should like to define what I mean by this. In deep anaesthesia the respiration is regular, automatic, and shallow, the larynx and pharynx are absolutely paralysed and immobile, and respond in no way to stimuli; the recurrent laryngeal nerve is paralysed and the cords stand in wide abduction. The pupil is generally dilated and does not react to light. All reflex activity of the pharynx and larynx is abolished, a Britting tube can be passed into the larynx, and there is no interference with the quiet rhythm of respiration and no spasm of the cords. The patient in this condition can take no active part in his own operation, he cannot cough. On the other hand, he cannot breathe out his own respiration by laryngoscopic observation. If this degree of anaesthesia is induced with ether the patient is pink and rosy, with a full regular pulse of about 80–91.

By light anaesthesia I do not, of course, mean a struggling patient. There is general muscular relaxation, the respiration is regular, but certain

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1 Abridged from a paper read before the joint sections of Anesthesiology and Laryngology of the Royal Society of Medicine on Feb. 6th.