

A new intragastric electrode / Anthony Bassler.

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A NEW INTRAGASTRIC ELECTRODE.

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The electrode herein described, in addition to the essential features necessary in such an instrument, possesses the added advantages of being easily and quickly introduced into the stomach or esophagus, of being comfortably borne by the patient during the treatment, and is practical in its strength of construction rather than a toy.

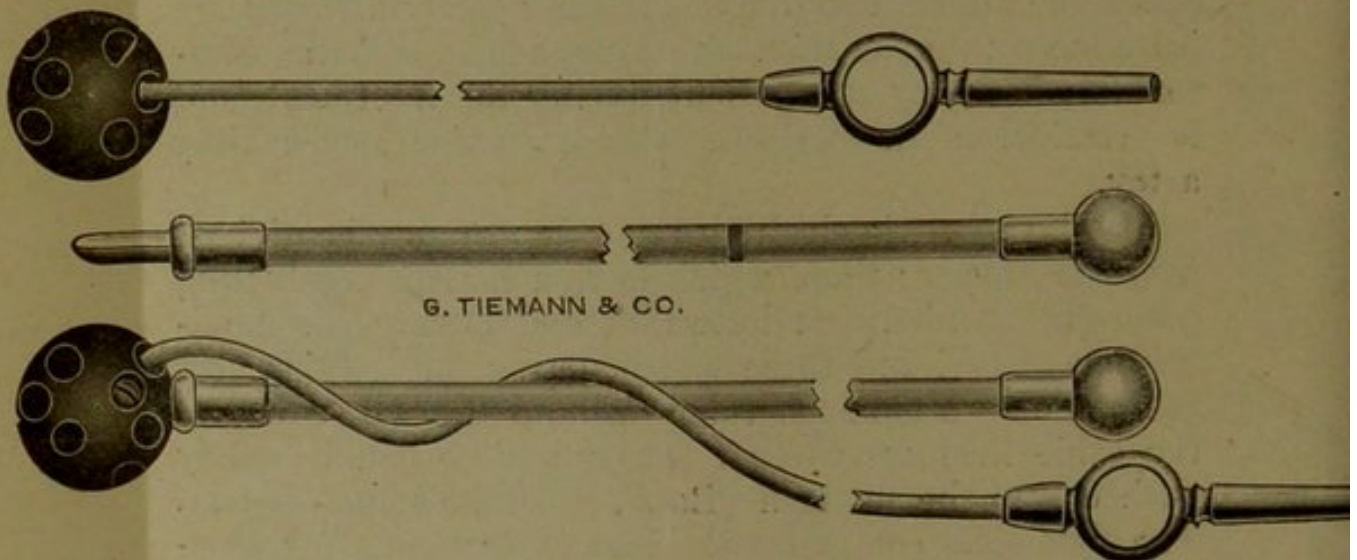
The intragastric electrodes now in use may be divided into two classes: those which have a narrow conducting cable (the Einhorn, and Ewald's and Lockwood's modification of it), and those which depend on a thick stiff tubing (like a stomach tube) around the wires to give the cable firmness so that the end piece can be easily pushed into the stomach (Boas', Stockton's and others). The first class comprises the best instruments for practical use, for the latter only magnify such objectionable features as may be found in most of the first group. The matter of irrigation during the time of the passage of the constant currents (possible in some of the electrodes of the second class) is not of much practical value in intragastric work, excepting in a few isolated instances.

The main objection to the deglutable electrode of Einhorn is the fact that it must be swallowed for its introduction. This is often a discouraging performance to patients, is time consuming and is not devoid of dangers to the physician (infections and abrasions from the teeth incident to placing the olive far back into the mouth of the patient). I have had patients who could not swallow or would vomit up the end piece even when the utmost care had been exercised in its introduction. Furthermore, as Lockwood has pointed out, the trailing

string of this instrument is a disadvantage, although in my hands not so much of a one as the first mentioned. Therefore, the deglutable feature is a decided drawback rather than an advantage in the constant use of this otherwise good instrument.

When a stiff straight wire (Ewald) or a spiral one (Lockwood) has been incorporated in the cable the valuable migratory feature of the Einhorn electrode is done away with, and the instrument is rendered uncomfortable for the patient to bear in the pharynx during the course of a treatment sufficient in length of time to obtain results.

Another objectionable feature to the American made Einhorn electrode is the thinness of the insulated rubber



Intragastric Electrode.

tubing about the wire. In practice, this rubber is constantly breaking down from wear and tear of use and the teeth of the patient. This objection is minimized to a degree by the thicker tubing to the electrode here shown, a modification now carried into effect in the German makes of the deglutable electrode. This thicker cable makes no practical difference in the comfort to the patient.

This new electrode consists of two separate parts, the electrode proper and the introducer. The end capsule of the electrode (13 mm. in diameter) is a hard rubber perforated case inclosing a metal ball in which the conducting cable is held. The introducer is the main feature of the instrument. It consists of a spiral wire covered with rubber tubing on which is marked the usual distance from the incisors to the stomach. At one

end of the introducer is a stem, flattened on one side, which fits into the metal ball. The flat surface prevents the ball from turning when the instrument is assembled for use. On the off end of the introducer is a round metal ball of no significance.

TECHNIC OF INTRODUCTION.

The patient is first made to drink a tumblerful or more of water; this is essential as a conductor of the current from the metal ball in the end piece to the external electrode. The introducer is lubricated with glycerin, then the electrode (which has been immersed in water) is mounted by slipping the spherical end on to the stem of the introducer after which one turn of the cable is made around the end of the introducer shaft. The entire instrument is inserted into the patient in the same way as is a stomach tube. At the desired point in the esophagus, or better in the stomach, the electrode is freed by simple direct withdrawal or by first making one or two short in and out movements of the introducer, the cable being free from the hand. The introducer is then withdrawn, leaving the electrode within the patient. It is my custom at this time to have the patient take another swallow or two of water. Care must be taken not to have more than one turn of the cable about the end of the introducer, and it is advisable to free the cable from the hand after the capsule had been delivered below the laryngopharyngeal junction.

WITHDRAWAL OF THE INSTRUMENT.

At the end of the treatment the electrode is withdrawn in the same way as is the simple deglutable instrument; that is, the string is drawn on until the ball end is held at the back of the larynx, then with an effort at swallowing (when the entroitus of the esophagus opens) the end of the instrument is delivered. I have used this electrode several hundred times with universal success and thus can recommend it as a most practical and satisfactory instrument.

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