Cape Town, 18 April 1964 Volume 38 No. 13 Deel 38 Kaapstad, 18 April 1964

EDITORIAL : VAN DIE REDAKSIE

DEATH IN A RESTAURANT

There are more ways of digging one's grave with one's teeth than simply overeating or even eating the wrong food. One of these ways, which is not often recognized, has recently been discussed by Haugen.[1]

A middle-aged or elderly person at a fashionable restaurant is enjoying a good party with his friends. He has got the main course and is partaking of a delectable fillet steak, or perhaps a lobster thermidor, or prime rib of beef. At the same time he is conversing volubly with his companions. Suddenly he ceases to eat and talk. His companions wonder what has happened, but are not alarmed because he shows no indication of acute distress. Then quite suddenly he collapses at the table. Attempts at resuscitation are immediately made by his companions, by the head waiter or the manager of the restaurant and by others—frequently a doctor may be present in the restaurant or even at the same party. An ambulance is sent for in emergency and the patient is rushed to the nearest casualty department, but on arrival is found to be dead. The casualty doctor, or possibly the family doctor, presumes that death was caused by natural causes, probably by coronary artery thrombosis.

This, however, is the tragic story of death from asphyxiation—blockage of the airway by a mass of food. Because of the age of the patient and the suddenness of death the attending doctor almost invariably signs the death certificate as coronary artery disease.

This type of death is not new, but is probably not well known to the medical profession. In fact, doctors have been present in restaurants where it has occurred without realizing what has happened.

In one state in America nine such cases have been discovered over the past few years. The victims ranged from 46 to 77 years of age; six were men and three women. At postmortem examination there was a moderate degree of arteriosclerosis in the brain in two cases, a severe degree in one case, and a certain amount of atheroma of the vessels of the heart in several. These findings were not considered to contribute to the cause of death.

The food that obstructed the airway was steak in four cases, beef in two, a wad of ham fat in one, kippered herring in one, and grilled lobster in another. In all cases the obstructing food mass was immoderately large—Haugen described it as 'atrocious' in all and 'abominable' in the first.

In the first case a piece of *filet mignon* three and three quarter inches by three inches by one inch was found at the entrance to the windpipe in a woman whose death had been attributed to a coronary attack. In her stomach were found two slightly smaller pieces of fillet, each measuring three and a half by one and a quarter by one inch. All these food masses had been swallowed without having been chewed at all. The victim had upper and lower dentures which were known to have been ill-fitting and to have caused irritation to the gums. A doctor who was present in the restaurant at the time arranged for the patient to be rushed to hospital, but she was dead on arrival.

The second case was very similar—again death was witnessed by a doctor and attributed to a coronary attack; again a piece of unchewed fillet 2½ inches across was found in the upper part of the windpipe. Again upper and lower dentures were found. In this case the level of alcohol in the blood was high—being 0·2 %.

The next death was that of a woman aged 46 years who collapsed in a local restaurant and was just alive but very blue when she arrived at hospital. The anaesthetist was called and tried to pass a tube down the trachea but came across the obstruction. He managed to retrieve a piece of steak which he described being as large as a man's tongue. The patient survived temporarily, but never recovered the full use of her brain and died after four days.

The fourth case was that of a man aged 77 years who collapsed at a restaurant and was rushed to hospital where he was thought to have died of heart disease. Postmortem examination, however, revealed obstruction of the lower part of the trachea; the obstruction was a piece of lobster four by one by one inch. The fish had got its own back by effectively sealing off both main bronchi. Again this patient had an upper denture and had one tooth only in his lower jaw.

A consideration of these cases indicated that a lack of ordinary table manners was of prime importance in the accidental deaths. It is remarkable that anyone should thrust such enormous pieces of food into his mouth, quite apart from swallowing them whole afterwards.

The state of dentition is also important. Inability to chew properly may have been a feature in most cases. In only one of the 9 patients recorded were the teeth reasonably normal, while the lack of evidence of mastication of the food further points to the importance of the teeth.

Four of the victims had high levels of alcohol in their blood streams, and some alcohol was present in three of the others. Presumably the level of table manners tended to fall as the level of alcohol rose.

It would appear to be difficult to remove the offending food mass even if a correct diagnosis is made at the time of the accident. Haugen considers that nothing short of a tracheotomy, below the level of the obstruction, would be of any help.

Today such accidents plainly should not happen. However, one may wonder how much more often this sort of death occurred in olden times, when man tore meat apart with his fingers, when dentures were not known, and large amounts of alcohol were drunk. We read in the history books of death occurring from 'a surfeit of lampreys'. Now it is clear to us how this could have happened.

1. Haugen, R. K. (1963): J. Amer. Med. Assoc., **186**, 142.

ASPEKTE VAN DIE PADONGELUK-EPIDEMIE

Belangstelling by die algemene publiek in die toenemende voorkoms van padongelukke neem byna (en tereg ook) die afmeting van 'n histeriese reaksie aan. Almal skryf en praat oor die onderwerp. Sommige skrywers meen dat die huidige padongeluksyfer onvermydelik saamhang met die inherente aard van ons moderne vervoerwese en dat niks of bitter min aan die saak gedoen kan word. By andere weer is daar so 'n oordrewe en verhewigde reaksie dat die allerdrastiese inperking van bestuursregte en voorregte voorgestaan en naarstiglik bepleit word. Op die individuele vlak het elkeen sy eie teorie: *spoed* is die belangrikste oorsaak van dié toedrag van sake, of *alkohol,* of *spoed en alkohol,* ens.

By amptelike instansies wek die toenemende padongeluksyfer groot kommer en sorg—in so 'n mate dat wyduiteenlopende planne vir optrede ter voorkoming van ongelukke voorgestel word. Daar is plaaslike en nasionale organisasies wat hulle slegs met die verspreiding van inligting en die instelling van opvoedingsprogramme besig hou. Geldsomme ter bedrae van honderde duisende rande word vir dié doel bewillig, en tog lyk dit of die toestand van sake by die dag versleg.

Dat daar inderdaad rede vir groot bekommernis is, val nie te betwyfel nie. As ons daaraan dink dat 'n enkele stedelike hospitaal, om maar net een voorbeeld te noem, jaarliks tussen elf en twaalfduisend pasiënte behandel wat die slagoffers van padongelukke is, kan ons 'n idee vorm van die enorme omvang en implikasies van padongelukke. Dit is skrikwekkend om morbiditeit- en mortaliteitsaspekte van die padongeluk-epidemie op nasionale vlak te bereken, om nie eens te praat van die onstellende vermorsing in terme van arbeid en onkoste nie.

'n Rasionele en objektiewe beskouing van die saak sal dit duidelik maak dat die oorsaaklike faktore wat betrokke is veel ingewikkelder is as wat saamgevat word onder die woorde spoed, of alkohol, ens. Ons het hier by uitstek met veelvuldigheid van veroorsaking te doen. Sulke uiteenlopende, oorsaaklike faktore soos die volgende is almal by die saak betrokke: die liggaamlike en geestestoestand van bestuurders sowel as van voetgangers, insluitende sulke sake soos verantwoordelikheid, betroubaarheid, hoflikheid, en die afwesigheid van moontlike presipiterende toestande soos epilepsie, floutes, diabetes, en baie ander siektes; die gebruik of misbruik van alkohol, kalmeermiddels en ander verslawende middels; die toestand van versorging en betroubaarheid van voertuie, paaie; weersomstandighede en ander fisiese faktore; te hoë en te lae en verkeerde spoed vir spesifieke verkeersomstandighede; die gemengde en uiteenlopende soorte van vervoermiddels en -metodes —en nog te veel ander om op te noem.

Dit is dus duidelik dat een liggaam of groep van persone noodwendig magteloos moet staan ten opsigte van die verlammende omvang en implikasies van die toenemende voorkoms van padongelukke. Om hierdie rede wil ons dus hier 'n benadering deur middel van diverse groepsverantwoordelikhede voorstaan. Laat ouers en onderwysers aandag gee aan die opvoedingsaspekte en voorkomende fasette van padveiligheid. Laat lede van die regsprofessie die kwessie van regsaanspreeklikheid uitpluis en swaarder strawwe oplê vir die verantwoordelike partye by alle ongelukke, laat voertuigversieners strewe na die hoogste standaarde van diens by nasien- en herstelwerk, laat provinsiale en staatsowerhede die openbare aspekte van veiligheid opknap en versorg, en laat ons as dokters op 'n verantwoordelike manier omsien na dié dinge wat binne ons bestek val.

As professie het ons as dokters in die verlede miskien te afsydig gestaan teenoor die voorkomende aspekte van padveiligheid. Die uitreik van bestuurderslisensies aan jongmense en oumense, aan mense met sintuig-gebreke en aan mense met siektestoestande moet onder veel strenger mediese beheer geplaas word. Die kwessie van motoriese vaardigheid in sover as wat dit betrekking het op bestuursvermoë is nog nooit volledig ondersoek nie; daar is mense wat nie 'n ordentlike knoop kan bind of 'n blikkie kan oopmaak of 'n skroewedraaier kan hanteer nie wat houtpopgelukkig voortsnel agter die stuurwiel van motors met verdwasende perdekragsterkte. En die versluierde karaktergebreke van padbuffels moet aan die indringende ontleding van beroepsielkundiges onderwerp word.

Die voorgaande is maar net enkele voorbeelde van gebiede waarop die mediese professie sy stem duideliker as in die verlede sal moet laat hoor as ons 'n volle aandeel wil hê aan die beveiliging van ons vervoerwese. Dit is 'n verantwoordelikheid en 'n uitdaging wat ons sal moet aanvaar, soos elke ander vertakking van die openbare beroepslewe dit ook sal moet doen, as ons hierdie aspek van ons lewe onder redelike en beskaafde beheer wil bring.