for spinal anesthesia in preference to sacral block anesthesia. . . . Although general anesthesia is suitable for most operations on the extremities, regional anesthesia is especially applicable for such procedures. . . . The choice of anesthesia for diabetic patients requires a thorough investigation of the condition of the patient and of the degree to which the disease has been controlled. The improvement in methods of treatment and the production of protamine-zinc insulin has done much to make the choice of anesthesia a less serious problem than it has been in the past. . . . The general opinion maintained today in regard to anesthesia for controlled diabetic patients is to disregard the fact of the diabetes and choose an anesthetic most suitable to the operative procedure, using ether sparingly if at all. When emergency operations are necessary, intensive preoperative and postoperative treatment should be carried out. . . . In the presence of acute respiratory and pulmonary infections, local and spinal anesthesia are preferable. If necessary, these may be supplemented with cyclopropane and oxygen or pentothal sodium administered intravenously and oxygen with or without nitrous oxide. Similar methods are used in the presence of chronic or quiescent pulmonary disease and should it be necessary for the more rapid and easy completion of the operation, small amounts of ether may be added. . . . Patients who have cardiac disease are not of necessity poor surgical risks, provided compensation has taken place and that the condition is not too far advanced. A careful examination, including electrocardiographic studies, should be made. It will be safer to avoid the use of cyclopropane if persistent cardiac irregularity is present, since it has been shown that this gas may produce cardiac irregularities and ventricular fibrillation. Advanced myocardial disease is a definite hazard under any type of anesthesia and when such a condition is present, local anesthesia is probably safest to use. Intravenous anesthesia is not safe when advanced myocardial disease is present, particularly if an associated dyspnea is present. Under these conditions, cardiac arrest may result from comparatively small doses of the barbiturate, the heart ceasing to beat before paralysis of respiration occurs."

J. C. M. (

CHRISTIANSEN, G. W.: *A Technic for General Anesthesia in Surgery of the Mouth.* J. Am. Dent. A. 27: 1575–1583 (Oct.) 1940.

"Nitrous oxide needs no introduction to dentistry. . . . there are factors to be considered before electing to use it: first, the patient; second, the task to be performed, and, third, the experience of the anesthetist and of the operator. . . . Premedication is of the greatest value for insuring smoother anesthesia. . . . During anesthesia, the patient should be comfortable, in a semirecumbent position to insure support with relaxation. A means of restraint must be provided. The dental chair meets the requirement well. Breathing is easier in this position than in recumbency, and a position favorable to emesis is immediately available by simply returning the chair to the upright. Reiterating the need for adequate provision to keep the mouth open seems unnecessary, and yet at least half of the trouble encountered in the extraction of teeth under general anesthesia is due to a lack of sufficient room in which to work. . . . Only occasionally in adults should an attempt be made to open the mouth and insert a prop after anesthesia has been established. Regardless of the pressure used, in the absence of relaxation, opening the mouth sufficiently to assure good vision for the operator is seldom

successful, and a power gag may displace teeth and lacerate soft tissues. . . . When a workable level of anesthesia is reached, as evidenced by fixation of the eyeballs and rhythmic respiration, the mouth is uncovered and a pack is inserted against the velum behind the mouth prop. . . . Hemorrhage is controlled by an aspirator and gauze sponges, to prevent saturation of the barricade pack. When the surgical procedure is finished on one side, the prop is moved and adjusted to exert pressure with the gauze on the bleeding surface. . . . When the operation has been completed, the packs are left until the reflexes are returning. Too early removal will let mouth fluids and blood run into the throat. Later removal will cause gagging. . . .

"Forward movement of the patient or downward pressure on the mandible may decrease the airway and invite progressive asphyxia. . . . Elevation of the mandible . . . corrects this. In the event that the mandible is short or there is labored breathing in an incumbent position, mechanical aid is of great value. . . . Generally speaking, nitrous oxide anesthesia causes cyanosis in plethoric and resistant types before a workable level of anesthesia is attained. If this level is deep and permits but a low percentage of oxygen in the mixture, the tissue supply of oxygen will soon be consumed, and if the level of anesthesia is continued without the addition of oxygen as saturation approaches, a real oxygen want will develop. . . .

"Just as examination and diagnosis precede intelligent therapeutic endeavor, they dictate the course of anesthesia. Disregard of important physical and structural contra-indications leads to complications. Such handicaps are not insurmountable, but they do require special precautions such as premedication or modification of technic or other additional aids. Nitrous oxide-oxygen anesthesia can be adapted to the patient's eccentricities however varied, provided preoperative investigation has been painstaking enough to reveal them."

J. C. M. C.

PHILLIPS, R. B.: *Intravenous Anesthesia and How to Use It.* Mil. Surgeon **87**: 301–305 (Oct.) 1940.

"Intravenous anesthesia has been proven to be a valuable assert in the armamentarium of the anesthetist in peace-times, and it should offer some important advantages to military forces, both army and navy. . . . Generally speaking, intravenous anesthesia is suitable for patients who are in good health, and who are having minor surgical procedures, or major operations of not too long duration. As a rule neither sodium pentothal nor evipal will relax the abdominal wall sufficiently to permit abdominal surgery. I have used pentothal in abdominal surgery in combination with abdominal block, or with N_2O, but not alone. . . . It is quite important that morphine and atropine be administered pre-operatively when using an intravenous anesthetic. . . .

"It will be comparatively easy to prepare small kits containing sufficient intravenous anesthetic agents for several hundred administrations, which will be easily transported, and will keep indefinitely. . . . Intravenous anesthesia is one of the quickest anesthetizing agents known, and has less pre- and postoperative complications than any other. It will be of great use in combatants who have been gassed and in whom gaseous anesthetics are out of the question. Whenever possible, always give oxygen with the pentothal or evipal, or at least see that it is available."

J. C. M. C.