

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 technique 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."

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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 asset 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 N₂O, 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.