

only way in which permanent autonomic block could be brought about. When only the rami were blocked, regeneration and recovery of function are possible. In such instances alcohol merely dissolves the myelin of the nerve sheath, leaving the pathway still intact for regeneration.

R. D. D.

BOSTON, F. K., AND JAMES, N. R.: *Rectal Hexobarbitone Soluble: a Useful Form of Basal Anaesthesia*. Brit. M. J. 1: 5-7 (Jan.) 1941.

"We have three main routes at our disposal for the administration of a basal anaesthetic: the oral, the intravenous, and the rectal. . . . We have used the [rectal] method . . . on more than 250 cases. . . . There is usually complete amnesia of the journey to and from the theatre and for some hours afterwards. . . . Less inhalation anaesthetic is required. The incidence of postoperative vomiting seems to be less than when inhalation anaesthesia is used alone. Compared with avertin, hexobarbitone soluble is easy to prepare and administer and rejection does not occur. The method is very suitable for combination with local infiltration and field block anaesthesia. . . . The above advantages, especially ease of preparation, make it suitable for Service patients under war conditions. . . . The only untoward effects we have observed have been as follows: Restlessness in a few patients. . . . In only two cases has undue respiratory and circulatory depression been seen in patients premedicated with morphine; these were given an unnecessarily deep ether narcosis following a full dose (e.g., 0.2 gramme per pound body weight) of rectal hexobarbitone. Since we have gained more experience in dosage we have not seen this complication. The above patients responded to intravenous coramine and inflation with oxygen. A second disadvantage was the

length of the period of postoperative unconsciousness; this might be a disadvantage in certain cases, such as when fluid therapy by mouth is indicated as soon as possible after operation—e.g., partial thyroidectomy, etc. The contraindications are those which apply to basal anaesthesia in general." 2 references.

J. C. M. C.

MALONEY, A. H.: *Picrotoxin in Acute Barbiturate Intoxication*. Clin. Med. 48: 34-37 (Feb.) 1941.

"The data presented in this study were derived from two general sources: (1) current medical literature, 66 cases; and (2) direct communications in answer to a questionnaire sent to 200 carefully selected hospitals and interested clinicians in the United States, 54. . . . In our review . . . we have found a total of 120 treated cases, with a fatal outcome, from all causes, in 20. . . . Of the 20 fatalities, 6 died acutely (one from right-side heart failure; 3 from undetermined causes; and 2 from depression), and 14 died from complications, chiefly pulmonary. . . . The efficacy of picrotoxin has been generally attested by all those who have had experience with its use in severe barbiturate poisoning." 9 references.

J. C. M. C.

BURSTEIN, C. L.: *Respiratory Depression During Anesthesia Attributable to Carotid Sinus Disturbances: a Clinical and Laboratory Study*. New York State J. Med. 40: 1767-1772 (Dec. 15) 1940.

"No function of the organism is so varied in its control as is pulmonary ventilation. Although there has been described a definite respiratory center in the formatio-reticularis of the medulla which regulates respiration, this center is merely the servant of a horde of impulses which reach it by way of practically every afferent nerve in the