

patient is prepared for thyroidectomy by rest, reassurance, Lugol's solution, phenobarbital, sugars, alkalis, acetylcholine of sodium, roentgen ray, or ligation. Avertin basal anesthesia in the room, following sedation and morphine, and followed by cyclopropane with its high O₂ administration, and novocain locally if desired, is the anesthetic of choice in the majority of these cases. Postoperatively, glucose, fluids, morphine, oxygen, transfusion, ice packs for hyperpyrexia, iodides and sedatives should be used as needed or indicated. . . . Neither cyclopropane nor spinal anesthesia offers any definite liver damage and from this viewpoint is preferable to ether. The development of a continuous spinal anesthesia technic by Lemmon at the Philadelphia General Hospital is interesting. For several years he has used this method of anesthesia in surgery below the diaphragm. . . . With small repeated dosages, the anesthetic is more controllable and it has been found useful on the surgical service at the Kansas City General Hospital where it is still in the study stage but is being found practical." 7 references.

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MALLINSON, F. B.: *Casualty Anaesthesia in the E. M. S.* Brit. J. Anaesth. 17: 98-107 (Jan.) 1941.

"In this war, owing to the development of intravenous anaesthesia and the modern gases and machines, there lies with the anaesthetist of the present day, the power vastly to improve the surgeon's chances of success, and decrease his inevitable mortality by the use of safer and less toxic anaesthetic agents than were available twenty-five years ago. . . . A careful consideration of the condition of the serious cases is first essential. Experience to date suggests that they are mainly divisible, from the anaesthetist's point of view, into three groups: (1) Immediate cases.

These resemble road accidents in many ways, but, unlike them, a strong factor of psychic shock may pre-exist, particularly with bombed civilians. (2) Recent (transferred) cases. Many of these are relatively clean, particularly the civilian cases, but others have been very toxic and ill with gas gangrene and other infections, such as many of the cases evacuated from Dunkirk. (3) Re-operation cases. These are recovering as a rule, and are relatively fit. They do not concern us. . . . The only claim that can be raised in favour of chloroform and ether is that of their portability. . . . Experience of spinal analgesia in the last war made clear how deadly it can be in shocked and hemorrhagic cases. This leaves us with the gases, nitrous oxide and cyclopropane, and the barbiturates, evipan and pentothal. Nitrous oxide is entirely without toxic effects on the body. When serious sequelae arise after its administration they are due to anoxaemia, as has been so convincingly shown by Courville. Cyclopropane is almost as non-toxic provided care is taken to avoid overdosage, shown by abnormal cardiac action, which if ignored can, though rarely, produce dangerous results. So much has been written about the quick-acting intravenous barbiturates that no advantage is to be gained from further discussion of them except to stress the opinion . . . that shock is not a contra-indication; properly administered, in fact, the reverse is outstandingly clear. . . . A careful enquiry should be made as to how much or how recently morphine has been administered to wounded persons, and a careful estimation made of the degree of shock and haemorrhage present. . . . The difference in post-operative condition between the etherized and the non-etherized patients has been amazing, and as a matter of clinical experience is far more impressive than any statistics." 12 references.

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