

ployed if the blood loss is minimal or if blood or plasma is not immediately available. . . . When it is necessary to administer fluids rapidly through a small needle, a hand roller will aid in propelling the solution through the rubber infusion tubing. . . . Poorly filled veins may be distended satisfactorily by the application of hot, moist packs to the extremities, if time permits. . . . The amount of the solutions needed for the support of a patient in shock will depend on the patient's need and response. . . . The excessive administration of fluid to patients in shock is dangerous and may lead to pulmonary edema and other ill effects. Excessive administration of fluids places an added strain on a heart muscle already weakened. The patient's pulse and blood pressure should be checked frequently during the course of the administration of fluid. In the successful treatment of shock the imbalanced condition should be corrected but it should not be overcorrected."

J. C. M. C.

SHUMACKER, H. B., JR.: *Local Anesthetic Reactions*. M. Ann. District of Columbia 10: 264-267 (July) 1941.

"More is known about precautions which may be taken to avoid local anesthetic reactions than is known about their treatment. The reactions are few in number, and local anesthesia is probably the safest of all anesthetics. Yet every care must be exercised. Proper labeling of solutions; use of only dilute solutions; use of adrenalin except when contraindicated; slow injections with care to avoid intravenous or intrapleural injection; the use of smaller amounts in regions where absorption is known or thought to be rapid, in old and very ill patients, and in those under general ether anesthesia; and the preliminary use of barbiturates should do much to reduce the incidence

of reactions and to make local anesthesia still safer." 2 references.

J. C. M. C.

FERGUSON, L. K., AND LA TOWSKY, L. W.: *A Study of the Immediate Postoperative Complications and Mortality in Certain General Surgical Operations. Analysis of 662 Cases at the Philadelphia General Hospital, 1936 to 1939*. Am. J. Surg. n.s. 53: 88-89 (July) 1941.

"This study was undertaken to obtain facts concerning the immediate postoperative complications and mortality in the cases commonly coming to the general surgical department of a large charity hospital. . . . A total of 662 cases was studied. . . . Complications were arbitrarily divided into five groups. The complications which occurred among the cases studied were as follows: 1. Wound Complications: Grades A, B, and C. 2. Abdominal Complications: Nausea and vomiting, postoperative distention, gastric dilatation, subdiaphragmatic abscess, pelvic abscess, peritonitis, fecal impaction. 3. Pulmonary Complications: Acute bronchitis, postoperative atelectasis, postoperative pneumonia, pulmonary infarct, pulmonary embolism. 4. Upper Respiratory Complications: Vincent's angina, acute follicular tonsillitis, upper respiratory infection. 5. All Other Complications: Liver shock, headache, decubitus ulcer, phlebitis, bleeding (wound), conjunctivitis, parotitis, incontinence of urine and feces, cystitis, toxic delirium, icteric toxemia, polyneuritis. . . .

"In considering the high mortality associated with cyclopropane (15.4 per cent) and local novocain (5.85 per cent) it should be mentioned that the poor risk patients received those anesthetics. The incidence of mortality in those patients receiving gas-ether and spinal novocain, the two most commonly used anesthetics, was very close,