

tubes are used with great frequency in this hospital and are always used in open pleura operations, we rarely use them in the presence of pulmonary tuberculosis. They are used in this case only when the sputum is unusually abundant. We are reluctant to use them in most cases of tuberculosis, for possibly new loci of tuberculous infection might develop in areas of slight trauma to the airway. During operation the patient is maintained in a slight Trendelenburg position. With termination of the study reported here, at the end of December 1940, all patients will have been followed for at least one year after their last anesthesia and operation. It would seem reasonable to suppose that damage possibly caused by the anesthesia would become evident within that time. . . .

"Our data include all cases, favorable and unfavorable. The surgical teams were constantly changing, the surgeons varying from members of the house staff to the chief of service. Notwithstanding these facts, our results for more than five years are such as to compare favorably with those from other clinics where ether is used either not at all or rarely. In our opinion, the anesthetic agent is not important in these cases as long as it permits the use of a plentiful supply of oxygen and allows the surgeon to carry out a deliberate, unhampered and unhurried operation, provided the patient is not jeopardized by toxic action of the anesthetic. It is important to choose an anesthetic agent which depresses vagal activity when thoracic surgery is contemplated. Ether exceeds other agents studied in this regard. While not enough data have been collected to permit final statement, several of the newer anesthetic agents appear to have a death rate in general surgery two or three times higher than in the case with ether. The excellent tolerance of the very sick

patient for ether anesthesia as well as the low death rate attributable to this agent is well established. After five years of study we can see no reason to abandon the use of ether in operations on the tuberculous patient because of the presence of tuberculosis." 18 references.

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GILLESPIE, N. A.: *Surgeon and Anesthetist*. J. A. M. A. 118: 787-790 (Mar. 7) 1942.

"Operative surgery, as we know it today, is the product of the last seventy-four years, for it was conceived by the publication of Lister's work in 1867. The surgeon himself, however, had long since won the respect and esteem of his colleagues to a degree which would have been inconceivable in the days of 'physician apothecaries' and 'barber surgeons.' That he did so was probably due to the fact that the early surgeon was learned in anatomy and skilled in clinical observation. . . . In anesthesia, unfortunately, the reverse has been true. . . . With the exception of a few such men as Snow and Hewitt the profession saw in anesthesia merely a technical advance ordained for the convenience of the surgeon. . . . Of recent years, however, there has been a renaissance of interest in and original work on the subject of anesthesia which has brought forth greater advances in the last thirty years than had occurred in the previous seventy. . . . Too much importance has been attached to the anesthetic agent and too little to the hands which use it and their degree of skill. . . . Surgeons, of all men, should have reason to know that a balanced judgment is more important than a method or a drug. . . . The anesthetist stands ready and willing to help the surgeon." 5 references.

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