

HERSHENSON, B. B.: *Some Observations on Anesthesia for Neurosurgery*. New York State J. Med. 42: 2111-2117 (Nov. 15) 1942.

"Our procedure of choice is to induce anesthesia in a lightly premedicated patient with a gaseous agent, using a closed inhalation system. When unconsciousness is reached, and to permit anesthesia to progress to the desired plane (the second plane of the third stage) without oxygen want, potentiation of the mixture may be had by the addition of a small increment of ether vapor. Cyclopropane has been employed as the agent of choice when indications for its use are present. Having accomplished the desired objectives—i.e., sufficient muscle relaxation and cord abduction—an attempt at direct intubation with a fairly large airway carrying an inflatable cuff is made. Should an adductor spasm or need for suctioning arise, the mask is reapplied and the depth of anesthesia readjusted for intubation. In the case presenting a bullneck and in other special problems an attempt at blind nasal intubation may be more practicable. . . . In the operating room the patient is placed in the position required by the neurosurgeon. A system of mirrors is so arranged that the surgeon can see the anesthetist and the anesthetist can see the field of operation. The anesthetic unit is placed next to the anesthetist but away from the surgeons. The anesthetist may now be so stationed that the patient's chest and at least one arm are available for observation and opportunity exists for observing and recording essential data. The closed absorption system is now smoothly conducted in the lightest possible planes of anesthesia. This system is supplied with air to which oxygen is constantly supplied at such a rate as is required to meet the metabolic needs of the particular patient. . . . The inhalation anesthetic agent is added at such incre-

ments to the enclosed air as is necessary to maintain the desired plane for the conduct of smooth anesthesia. . . . Provided such a closed system as we have described is used, of all known and available gaseous agents cyclopropane possesses certain fundamental physiologic and pharmacologic advantages for the modern neurosurgical team." 10 references.

J. C. M. C.

MORGAN, A. D.: *Shock and Anaesthesia in Relation Thereto*. M. J. Australia 2: 193-198 (Sept. 5) 1942.

"Treatment of shock is no longer the responsibility of a single person, but is jointly undertaken by the surgeon, the anaesthetist and often quite a team of assistants. For the best results it is important that this teamwork and team spirit should be developed to a high degree. . . . General therapeutic measures are all well understood, universally accepted, and should be applied without delay in all cases of shock. They are as follows. The causative factors producing shock should be removed or controlled . . . so far as these are possible without an anaesthetic. . . . The importance of rest cannot be too strongly stressed. . . . The administration of adequate morphine for the relief of pain is an essential measure of treatment. . . . Morphine dosage should never be empirical in cases of shock. . . . Promotion of warmth, or rather the minimization of heat loss, can be assisted by the use of warm blankets, radiant heat and hot air; but by far the most satisfactory method is a special room in which both heat and humidity can be controlled. Whatever differences of opinion may exist about many aspects of shock, there is universal agreement that its end result is diminished tissue respiration—*anoxia*. Oxygen in adequate dosage, then, is always necessary in the treatment and prophylaxis of shock. . . . In blast injury, in which the al-