

placed on the table. Preoperative sedation is prescribed by the surgeon."

J. C. M. C.

HINGSON, R. A., AND EDWARDS, W. B.: *Continuous Caudal Analgesia in Obstetrics*. J. A. M. A. 121: 225-229 (Jan. 23) 1943.

"Continuous caudal analgesia was developed to relieve the pains of labor and delivery. Since its beginning we have sought to improve our apparatus and refine our technic in order to provide the maximum of comfort for the mother with a minimum of risk for her and the baby. . . . In a previous paper, we wrote that we used this procedure in obstetrics only after it had been thoroughly studied in the management of twenty surgical operations on the perineum and lower extremities. We first used it in our surgical service, working with Southworth, in October 1941 for a bilateral phlebectomy. Since that time we have managed the entire course of six hundred labors and deliveries with this method without resorting to any other form of anesthesia. . . . In the series of 100 cases of delivery handled by continuous caudal analgesia, the percentages were as follows in the U. S. Marine Hospital, Stapleton, N. Y.: primiparas 89 per cent, multiparas 11 per cent, cephalic 98 per cent, anterior 84 per cent, posterior 14 per cent, breech 2 per cent. In this series there were only 3 per cent unsatisfactory cases in which supplementary anesthesia was necessary. Since Jan. 1, 1942 we have either managed or supervised the labor and delivery of 489 additional cases in the clinics of nineteen medical schools and teaching hospitals. In this group there were eleven breech deliveries, one set of twins and one cesarean section. Of this series 11 per cent obtained unsatisfactory analgesia, necessitating either discontinuance of the method or the addition of supplementary anes-

thesia. In many of these cases the technic was being practiced by residents who were learning the procedure. In the entire series of 589 cases there were 586 live births with no maternal complications or deaths. The average length of time the analgesia was continued was six and one-half hours. The shortest was thirty-five minutes and the longest was thirty-three hours. The average metycaïne dosage was 2.6 Gm. The maximum dosage given was 11 Gm.

"In cases of toxic hypertension it was noted that after the analgesia had been in effect for about forty-five minutes the pressure reached a plateau which corresponded to their normal before they became toxic. This drop persisted until after delivery and in the cases observed did not return to the toxic peak. All the patients stated that they felt much better. . . . This method involves a new analgesic technic which should be studied under those who have been trained in the method before it is employed in practice. Obviously, the method depends also for its success on a high degree of obstetric competence, avoiding cases in which there are contraindications, avoiding meddling or hasty obstetric intervention and observing well established criteria for observation of the progress of the delivery." 13 references.

J. C. M. C.

GREADY, T. G., JR., AND HESSELTINE, H. C.: *Continuous Caudal Anesthesia in Obstetrics: Preliminary Report*. J.A.M.A. 121: 229-230 (Jan. 23) 1943.

"Continuous caudal anesthesia has a place in obstetrics. There are some dangers and contraindications to this method. Cautious but repeated experiences with the method are desirable to evaluate it. These preliminary observations with some of the advantages and disadvantages are presented in the