

those skilled in this procedure. 5. At laparotomy (cesarean section) the peritoneum is not sensitive as it is when done under local anesthesia. 6. Patients in labor are calm, quiet, relaxed and rational. 7. It makes use of the principle of giving repeated amounts of a drug over a long period of time.

“Some of the conditions which present themselves and which might be presumed to be disadvantageous and dangerous are: 1. The greatest danger would seem to be that of injecting this amount of drug into the subarachnoid space. . . . 2. There is a loss of the subjective pain element as an aid to following the progress of labor. 3. . . . It is not a time saving procedure, since a skilled person must insert the needle and inject the medication at intervals of thirty minutes or longer. . . . 4. It either prolongs the second stage or increases the incidence of operative delivery, since the patient has absolutely no urge to bear down. 5. While this type of anesthesia has the advantage of providing a contracting uterus for normal labor and third stage, it is not the procedure of choice when a difficult forceps rotation or version is necessary, since here almost complete uterine relaxation is imperative. 6. Since 1 toxemic patient had a vasomotor or shock reaction, other toxemic or severe hypertensive patients have not been tested with this method. 7. It is assumed that the successful administration will increase from 70 per cent in the series of 20 patients to a distinctly more favorable rate as experience and judgment increase. . . . 8. The method does not give abdominal wall relaxation as compared to deep inhalation anesthesia. 9. That spinal anesthesia is

contraindicated in cardiac patients with myocardial damage is a general belief, and the same may apply for continued caudal anesthesia. 10. At this time the procedure seems to be one exclusively for hospital usage because of the danger of complications. It is our belief that in carefully supervised and selected cases continuous caudal anesthesia is a valuable addition to the field of obstetric analgesia and anesthesia, and our work with it is continuing.” 1 reference.

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MINNITT, R. J.: *Analgesia and Anesthesia in Midwifery*. M. Press. 208: 410-412 (Dec. 23) 1942.

“Some years ago there was a great agitation in many quarters for the development of an efficient method for the relief of the pains of labour. . . . In the year 1933 a specially designed apparatus for gaseous inhalation was produced, and a technique of administration developed in order to try to procure the desired result. . . . During the winter of 1933 and the early part of 1934 an investigation into the value of this new treatment was conducted. . . . The following facts were noted: (a) The procedure was simple and inexpensive. (b) There was no danger to mother or child. (c) Relief from the pains of labour was given in a very high percentage of cases. (d) Labour was not prolonged. . . . Many different machines have been manufactured for the purpose of giving gas and air analgesia, but one underlying principle controls them all, viz., self-administration, which means that there is no flow of gas unless the patient inhales.”

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