

eases. Serious complications in individuals neurologically normal are relatively infrequent and in properly selected cases spinal anesthesia still holds an important place in the surgeon's armamentarium." 31 references.

J. C. M. C.

ADAMS, W. B.: *The Prevention and Treatment of Postoperative Pulmonary Atelectasis by the Stir-up Regimen and Tracheobronchial Toilet*. J. Indiana M. A. 36: 299-301 (June) 1943.

"In order to prevent atelectasis during anesthesia, and in the immediate postoperative period, from the rapid absorption of anesthetic gases, the anesthesiologist adds to the mixture some inert gas, such as helium or nitrogen, which is slowly absorbed, and presses gently on the rebreathing bag during inspiration to force gases to the more distant alveoli. It is easier to prevent atelectasis than to cure it. Another method for prevention of atelectasis in the postoperative period is the stir-up regimen so widely advocated by Dr. Waters. This consists of three simple points: 1. The patient must radically change his position. 2. He must cough vigorously. 3. He must take several deep breaths. . . . Unquestionably bronchoscopic drainage is the treatment of choice for atelectasis and bronchial obstruction. . . .

"The patient may sit or recline in bed; usually some elevation of the head of the bed is helpful. Twenty minutes is spent in carefully and progressively spraying an anesthetic solution on the nose, base of tongue, fauces, pharynx and vocal cords. . . . Select the endotracheal tube to be used, choosing the largest one which will pass readily through the nostril if that route is decided upon—a slightly larger size may be used for direct insertion. . . . Lubricate the tube well with an oint-

ment containing 1 per cent nupercaine or diothane to reduce the sensitivity of the vocal cords. When introducing the tube according to the method of Magill, insert it slowly, convexity upward, into the more spacious nostril. By adjusting the degree of flexion and rotation of the head, and by having the patient pant as the tube nears the cords, the tube will usually enter the glottis. . . . A spray from the nebulizer directed into the tube during inhalation reduces the sensitivity of the tracheal mucosa. The aspirating catheter should be size fourteen to eighteen, French, and should have six to eight perforations near the tip. Lubricate the catheter with a thin layer of grease and attach it to the suction machine. Now insert the catheter full length into the endotracheal tube. Violent coughing, which marks the contact of the catheter with the tracheal and bronchial mucosa, squeezes out any fluid or mucus present and dislodges many bronchial plugs. Move the catheter gently in and out, twisting it, and change the position of the patient from side to side so that it will enter both main bronchi. . . . Withdraw the catheter and the endotracheal tube and terminate the procedure when no more secretion can be obtained." 5 references.

J. C. M. C.

BEECHER, H. K., AND CRAIG, F. N.: *Tissue Metabolism following Shock Induced by Hemorrhage*. J. Biol. Chem. 148: 383-392 (May) 1943.

"In the many years surgical shock has been studied by laboratory methods, a considerable body of data has accumulated to show that gross metabolic abnormalities, understandably enough, accompany the development of shock; these increase as shock persists. . . . In all of these previous considerations of metabolic abnormalities in shock we find no detailed studies of the