tate the handling of abnormal presentations, including occiput posterior, transvere arrest and breech presentations. . . . We would reëmphasize that the method is best performed by a specialist, in a hospital." 28 references.

J. C. M. C.

IRVING, F. R.: *An Improvement in Catheter Technic for Continuous Caudal Anesthesia.* J. A. M. A. 122: 1181 (Aug. 21) 1943.

"Recently Adams and Lundy described the catheter for continuous caudal anesthesia. The method they described involved the use of a 13 gage Love-Barker spinal needle and a number 5 ureteral catheter. We have used this method in over 250 obstetric cases without any serious complications. . . . Recently we have . . . simplified the technic considerably by employing a 15 gage needle with obturator and a number 4 ureteral catheter. . . . For obese persons or for patients with a small sacral foramen we use a special 18 gage needle 5½ inches long. . . . We employ this needle in the difficult cases. After it is inserted, the 15 gage needle without the obturator is passed over it as a sleeve. The 18 gage needle is then removed. The number 4 ureteral catheter is inserted into the caudal canal through the 15 gage needle, which is withdrawn, leaving the catheter in place. A 25 gage hypodermic needle is inserted into the external end of the catheter, which is connected by an adaptor to an injection system similar to that described by Hingson and Edwards. The 15 gage needle can be used direct in over 75 per cent of cases, the hubless 18 gage needle being reserved for the difficult patient. We have employed this method in over 100 cases." 4 references.

J. C. M. C.

RUTHERFORD, R. N.: *Continuous Caudal Anesthesia in Obstetrics.* West. J. Surg. 51: 6–11 (July) 1943.

"Hingson and Edwards in 1942 applied the principle of continuous caudal anesthesia not only to delivery but also to relieve the pains of first and second stage labor. Their preliminary report on 65 cases has been simplified by subsequent reports from their own group as well as by other investigators. . . . Again we are forced to conclude that the ideal obstetrical analgesia and anesthesia yet glimmers in the distance, for certain technical limitations hamper this procedure as firmly as any of the other agents in more frequent use. The anesthesia still must be adapted to the individual patient with her peculiar needs."

J. C. M. C.

SMALL, M. J.: *A Serious Complication of Caudal Anesthesia.* J. A. M. A. 122: 671–672 (July 3) 1943.

"A secundigravida aged 23, whose previous medical and obstetric history was noncontributory except for a syphilitic infection, acquired five years previously but adequately treated and with negative serologic and spinal fluid findings at present, was admitted in active labor with the cervix three fingerbreadths dilated and the head in midpelvis, the presentation being left anterior oblique. The membranes were intact. Blood pressure was 120/80. The general medical examination revealed no abnormalities. Caudal anesthesia was begun immediately, the technic recommended by Hingson and Edwards being used with one modification. . . . This procedure. . . . utilizes the ordinary intravenous drip arrangement for a slow continuous flow of anesthetic solution instead of the injection of large quantities of solution at intervals. . . . With this