thesia. . . . These observations indicate that when marked dilatation occurs in one peripheral vascular bed, owing to paralysis of the sympathetic supply, concomitant vasoconstriction occurs in certain other remote peripheral beds. The mechanism involved seems to be one of adjustment, possibly compensation, through efferent pathways of the sympathetic system. . . . The method may be useful . . . for clinical studies of the effects of numerous physiological stresses, such as those preceding shock, upon such pathways and upon small peripheral blood vessels." 8 references.

J. C. M. C.

RANKOW, R. M.: *The Pterygopalatine Injection for Block Anesthesia of the Maxilla.* Mil. Surgeon **93**: 164–167 (Aug.) 1943.

"During the past two years, I have closely followed the technique described by West (who credits Silverman), and more recently by Peckham, for blocking the maxilla by injecting the anesthetic into the pterygopalatine fossa through the greater palatine foramen. The administration of over two hundred such injections with gratifying, uncomplicated success leads me to proffer its use for military dentistry. . . . An anatomical approach enhances the success of block anesthesia for the maxilla. The application of these principles to the pterygopalatine injection simplifies complete maxillary block for certain indicated maxillofacial procedures." 3 references.

J. C. M. C.

MOORE, A. E., AND GUTHRIE, D. W.: *Amputation Under Ice Anaesthesia.* New Zealand M. J. **42**: 97–101 (June) 1943.

"In using refrigeration anaesthesia the limb, of course, is not actually frozen. The technique depends upon merely chilling the limb to about 2° Centigrade, and at this temperature metabolism practically ceases, but although there is complete anaesthesia of protoplasm, there is no actual coagulation such as there is in a frostbite, where the temperature of the part reaches freezing point. . . . This method has now been used in five cases at the Auckland Hospital. . . . Since submitting this article for publication this method of anaesthesia has been employed in five other cases in Auckland Hospital. There has been no death in this series of ten cases." 5 references.

J. C. M. C.

MONTGOMERY, T. L.: *The Present Status of Analgesia and Anesthesia from the Obstetrician's Viewpoint.* Pennsylvania M. J. **46**: 1048–1050 (July) 1943.

"Despite all . . . [the] adjustments in practice and . . . corrections which have served to reduce the mortality of mother and child, I believe that all obstetricians, enthusiasts or otherwise, are ready to agree that we have not yet found the ideal analgesic agent. When we do find such an agent, it will be one which is local in its effect and not systemic. . . . The method of continuous spinal anesthesia, as introduced by Dr. William T. Lemmon, has been employed in a sufficient number of cesarean sections now to indicate that it is an acceptable and useful anesthetic method. I think that continuous spinal anesthesia should be employed particularly where one is undertaking an extraperitoneal cesarean section. . . . The method of continuous caudal anesthesia . . . has been employed not only in perineal operations of one type or another but has been introduced in obstetric practice for continued application during the first and second stages of labor . . . This new procedure possibly will find a great field of application in ob-

stetric practice. . . . Before we can completely accept this new remedy, it will have to be tried by competent observers in many clinics."

J. C. M. C.

BRENTNALL, C. P.: *Local Anaesthesia in Vulval and Vaginal Surgery.* J. Obst. & Gynaec. Brit. Emp. **50**: 226–232 (June) 1943.

"The term 'local anaesthesia' is used in its widest sense, and includes the procedures sometimes referred to as 'regional anaesthesia,' 'field block,' and 'nerve block.' The anaesthetic used has been Novutox, a proprietary preparation containing a solution of Procaine with epinephrine in Ringer's solution, and also quinine derivatives and and thymol. . . . It has been used in various dilutions from ½ to 1 per cent of Procaine with almost equal success. . . . The total amount injected in this series has rarely exceeded 40 cc. in a single operation. . . . It is obvious that the technique of local anaesthesia for gynaecological surgery of the vulva and vagina will vary considerably from case to case. . . . If a comparatively small area (such as the labia) receives sensory nerve fibers from a number of nerves, it is both easier and more successful to infiltrate the tissues with the anaesthetic than to attempt a block of each individual nerve. But when a large area (such as the vagina) receives its nerve supply from a single nerve or nerve plexus, it is preferable to block the nerve rather than infiltrate the tissue. . . . The question of premedication of patients about to undergo operation is debatable. . . . Morphine, together with scopolamine, has given the best results. . . . The contra-indications to the use of local anaesthesia may be classified under three headings: 1. Acute inflammation. . . . 2. Anatomical obstruction to the site of injection. . . . 3. Pathological obstruction to the site of injection. . . . With the exception of those exhibiting one or other of the above contra-indications, a small and almost negligible list, it may be said that any vulval or vaginal operation may be completed with success under local anaesthesia with one exception, namely, excision of the vulva. It has been found that excision of tissue down to the fascia covering the pubes and deep to the clitoris is painful, and success is not claimed. . . . Although I have used this technique for every vulval and vaginal operation that is included in my practice of gynaecology, only once has it been necessary to administer a general anaesthetic." 5 references.

J. C. M. C.

HOENIGSBERGER, F.: *Collapse under Pentothal Sodium Anaesthesia.* Lancet **2**: 14 (July 3), 1943.

"A miner, aged 40, of spare build, was admitted in the early hours of the morning with a compound fracture of the tibia and fibula and, in addition, a fracture of the neck of the femur. . . . A smooth induction was obtained with 3 c.cm. of a 5% solution of pentothal sodium. After a short pause, a further 5 c.cm. of the same solution was injected more slowly and it was found that narcosis was still fairly light, the respiratory excursions being good. A further 4 c.cm. was injected slowly after a short interval, while the operation was being begun. At this stage, 10 minutes after the start of the injection, pallor appeared suddenly and respiration ceased abruptly. The pulse was found to be very weak, fast and irregular in time. Artificial respiration with pure oxygen by means of a rebreathing bag was started without delay and satisfactory chest expansion was obtained through an oral airway. The pupils were contracted at this stage. After 3 minutes there was no spontaneous attempt at respiration and