

anesthesia the operations are usually easy and uneventful. . . .

"When we have localized the cyst and have placed the patient in the position for operation, the anesthetic is administered, first with a simple mask; then, when the patient is asleep, a tube is placed in the trachea by way of the nose. This is done easily and usually without trouble. If there are, however, certain obstacles caused by deviations in the anatomy of the nose, or any other reasons, the tube may be introduced through the mouth, which is equally simple. The intubation is usually done when the patient is asleep, but sometimes it is done when the patient is awake, following local anesthesia to the pharynx. There are still surgeons who carry out the operation in this way. . . . After the ribs are resected, the pleura is opened and at that moment the anesthetist, to diminish the intrapulmonic pressure, permits a slight pneumothorax. . . . Once the precise localization of the cyst is established the lung is again distended and there is usually no need to surpass 18 mm. of mercury in pressure. . . . The lung is kept inflated and if there are any bronchi of sufficient caliber to affect the intrapleural pressure, opening into the cyst, it is convenient to increase the intrabronchial pressure." 12 references.

J. C. M. C.

FOLDES, F. F., AND BEECHER, H. K.: *The Effect of Cholesterol Administration on Anesthesia*. *J. Pharmacol. & Exper. Therap.* 78: 276-281 (July) 1943.

"In the early years of the present century considerable interest was aroused in relationships existing between lipoids and anesthetic agents by the extraordinary findings of Meyer and Overton and their immediate followers. . . . In 1936, Starkenstein and Weden published a paper discussing

the influence of cholesterol administration upon the activity of hypnotic and anesthetic agents. The purpose of the present study is to repeat in part the experiments of Starkenstein and Weden, and to obtain sufficient data to establish the fact of an additive or potentiating effect of certain lipoids on anesthetic action not only in the case of a volatile lipid soluble anesthetic agent, ether, but also in the case of a non-volatile agent, a barbiturate (pentobarbital sodium). . . . We have confirmed for ether and a barbiturate the principal conclusion of Starkenstein and Weden that the depth and duration of anesthesia can be greatly increased by the previous injection of cholesterol. The cholesterol effect appears to be a potentiation; the possibility that it may be additive cannot be eliminated at this time. In searching for an explanation of the cholesterol action one must look beyond physical solubility and transport effects: (a) Both olive oil and cholesterol increase the effectiveness of ether, but only cholesterol increases the effectiveness of the barbiturate. Olive oil has no effect on the barbiturate. (b) Ether has the same order of solubility in both cholesterol and lecithin: yet the cholesterol increases the anesthetic effect of ether (and the barbiturate) while the lecithin does not." 6 references.

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QUERIES AND MINOR NOTES: *Sudden Death and Anesthesia—Fundamentals of Anesthesia*. *J. A. M. A.* 122: 1215-1216 (Aug. 21) 1943.

"To the Editor:—A white woman aged 21, whose weight was 110 pounds (50 Kg.), requested a tonsillectomy. Her past history was negative except that she had always been nervous. . . . The patient was given morphine sulfate $\frac{1}{8}$ grain (0.008 Gm.) and atropine sulfate $\frac{1}{200}$ grain (0.00032 Gm.) one-half hour before operation. Induction