

nary but sweeping character, namely, that shock is reversible at all stages. It has been explained that this result does not imply saving of life in all cases, though a later paper will give examples of the reversal with quantities of fluid which are compatible with permanent recovery, in shock produced by the same and various other methods. This partial publication, leaving references and various details to be supplied later, has seemed advisable in the existing war emergency, because the experiments if confirmed may suggest clinical trials in cases of shock which are hopeless under present methods."

J. C. M. C.

NOSWORTHY, MICHAEL: *A Method of Keeping Anaesthetic Records and Assessing Results*. Proc. Roy. Soc. Med. 36: 468-471 (July) 1943.

"The present aim was to combine on the same card the usual anaesthetic chart for collecting and recording all the relevant data as well as a method for assessing results statistically without having to use either a code book or a sorting machine. The anaesthetic record is printed on a card 8 in. by 5 in. in size. . . . Around the four sides of the card holes are punched. What each group of holes and each individual hole represents is shown by headings and subdivisions printed against them on the front of the card. . . . The data collected at operation, like other positive factors noted on visiting the patient during his stay in hospital, are subsequently marked with a circle in their appropriate subdivisions round the sides on the front of the card. When the patient has left hospital the holes opposite the encircled positive factors are converted into slots by cutting out a 'V' from the edge of the card opposite each with a pair of special nippers or scissors. . . . Sorting of a pack of completed records

is accomplished by running a knitting needle through the hole representing the factor under consideration, by spreading the pack over its length in order to prevent any cards from clinging together, and then by raising the needle. . . . By repeating this manoeuvre it is possible to find quickly a statistical data required—e.g., the number of a given type of operation performed under a particular anaesthetic technique and the post-operative morbidity and mortality, &c."

J. C. M. C.

H. P. R.: *Caudal Analgesia Publicity*. M. Ann. District of Columbia 12: 271-273 (July) 1943.

"The 'de-Kruffian' style of recent la publicity . . . deserves comment.

"Following the work of Lemmon and Lemmon and Paschal on continuous spinal anesthesia, Hingson and Edwards announced their method of administering continuous caudal analgesia in obstetrics. . . . The pioneer work . . . has been followed by articles by Gready and Hesselstine . . . Block and Rochberg . . . Adams Lundy and Seldon . . . for obstetric analgesia. . . .

"The method involves the use of a long, malleable needle . . . for the transmission of a local anesthetic agent to the caudal canal epidurally, the hook-up remaining in place throughout labor. . . . There have resulted a large proportion of cases in which highly satisfactory analgesia was obtained. However, contraindications have been noted: placenta previa, inertia uteri, hysterical or psychotic states, disproportion, difficult rotations and versions, hypersensitivity to local anesthetic agents, infective processes over the sacrum and sacral hiatus, and congenital or traumatic malposition or configurations of the vertebral column, especially of the sacral segment. Complications do not often occur but