

cords; ankylosis of the jaws; goiter; extensive disease of the lungs; diabetes; cyanosis; intestinal obstruction, and advanced debility." 39 references.

J. C. M. C.

PRICE, H. J.: *The Relief of Acute Pleuritic Pain by Intercostal Nerve Block*. J. A. M. A. 123: 628-629 (Nov. 6) 1943.

"My purpose in this report is to describe a procedure of relieving pleural pain by inducing intercostal nerve block with procaine hydrochloride. This method is simple and effective, often producing permanent relief of the pleural pain associated with pneumonia. It allows relatively free motion of the thoracic wall and so favors adequate aeration of the lungs, affording protection against the complication of atelectasis. Drainage of the involved area of the lung is promoted, for coughing is rendered nearly painless. . . . The nerves to be injected are those corresponding to the intercostal spaces over which definite tenderness can be elicited by slight pressure. The injection is made most conveniently in the posterior axillary line or anterior to this. However, in instances in which the hyperesthesia is located more posteriorly, injection can be made in the midscapular line. A procaine hydrochloride wheal is first made in the overlying skin. A 20 to 21 gage needle is then introduced through the anesthetized area of skin until contact is made with the outer border of the rib immediately above the selected space. The periosteum is anesthetized with a few minims of procaine hydrochloride, after which the needle point is carried down to the inferior margin of the rib, where it falls into the groove occupied by the intercostal nerve and vessels. At this point traction is exerted on the plunger until the operator is certain that the needle has not entered a vessel. If no blood is drawn, the nerve

is then infiltrated with 2 cc. of a 1 per cent solution of procaine hydrochloride. . . . In a series of 14 consecutive cases, severe pleural pain was relieved effectively by intercostal nerve block. The resultant improvement in the general condition of the patients was striking. Anxiety disappeared, and most patients fell asleep shortly after the procedure was completed. For some this was the first rest in many hours. 3 references.

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IGLAUER, SAMUEL: *Bronchoscopy as Diagnostic and Therapeutic Procedure*. Nebraska M. J. 28: 340-343 (Nov.) 1943.

"Atelectasis may occur in a segment of a lobe, in a single lobe, or as a massive involvement of an entire lung. In this paper only post-operative atelectasis will be considered. It occurs most frequently after high laparotomy, but may follow operations on any part of the body. The predisposing factors are aspiration and retention of mucus and saliva during the operation. After laparotomy, splinting of the abdominal muscles from pain, tympanites, trapping of air under the diaphragm, and tight bandages all interfere with the diaphragm. As a result the secretion within the bronchi can not be expelled, especially if the patient refrains from coughing or if the cough reflex has become abolished from the administration of morphine. Massive collapse is as common after spinal or local anesthesia as after inhalation anesthesia. The diagnosis of this condition is confirmed by the roentgenogram. The diaphragm on the affected side is elevated and is associated with narrowing of the intercostal spaces. The heart and mediastinal structures are shifted toward the opaque collapsed lung. . . . Bronchoscopic treatment should most frequently begin in the operating room. When the anesthetist states that the