

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 percent 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.

J. C. M. C.

IGLAUER, SAMUEL: *Bronchoscopy as a 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 secretions 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

patient has aspirated large quantities of secretion or vomitus during the operation, . . . a prophylactic bronchoscopic aspiration should be performed before the patient leaves the table. Post-operatively, bronchoscopy and aspiration are indicated whenever the ordinary measures such as exciting the cough reflex, change of posture, 'rolling' and CO₂ inhalations fail to relieve the condition. If the patient can not be moved bronchoscopy under local anesthesia can be performed with the patient in bed. At bronchoscopy one almost invariably finds a thick tenacious mucoid or mucopurulent plug in the bronchus. After removing the secretion the lung usually reexpands and the relief afforded the patient is sometimes dramatic. Usually a single bronchoscopy suffices, but a second or third treatment should be given if indicated.

"In my opinion many cases of so called post-operative pneumonia or lung abscess originate from failure of the surgeon to avail himself of this comparatively simple procedure and provisions should be made in every well equipped hospital for its employment. . . . Bronchoscopic aspiration of purulent secretion for the protection of the sound lung is necessary immediately before and after undertaking lobectomy for pulmonary suppuration." 10 references.

J. C. M. C.

DAVIS, M. B.: *Convulsions under Ether Anesthesia*. J. Tennessee M. A. **36**: 373-374 (Oct.) 1943.

"Nancy St. C., white female, age four, admitted to St. Thomas Hospital in February, 1938, with diagnosis of acute appendix. . . . Very acutely inflamed appendix was removed. As I was closing the peritoneum, the patient started generalized twitching and then began having violent convulsions. Dr. James Overall was present, who gave

sodium luminal intravenously and started saline clisis. Within a few minutes the convulsion ceased. Her convalescence was uneventful. Elizabeth R., white female, age seven, admitted to St. Thomas Hospital in May 1941, on a very hot day. . . . Acutely inflamed appendix removed. Patient developed mild convulsions about midway of the operation. Dr. Milton Lewis was present and administered sodium amytal, which controlled her convulsions and allowed the operation to be completed. Twelve hours following the operation, patient broke out with a deep rash, probably toxic in nature. This cleared up in two days and her convalescence was otherwise uneventful." 5 references.

J. C. M. C.

GOLDSCHMIDT, MARGOT W.: *Two Complications with Trichlorethylene Anesthesia*. The Lancet **2**: 414 (Oct 2) 1943.

"The two noteworthy incidents here reported occurred among a series of some 175 minor or major operations under trichlorethylene. . . . A healthy man of 22, very muscular and emotionally well-controlled, was admitted to the surgical outpatient department of the Royal Infirmary for reduction of a Pott's fracture. . . . No premedication was given. Induction with nitrous oxide and oxygen was smooth. Trilene from the chloroform bottle of the Boyle's machine was added to produce the necessary muscular relaxation. About M 60 of trilene was used. . . . The patient was allowed to come out of the anaesthetic with the gas reduced and oxygen increased. Presently the patient started moving, and suddenly a few clonic convulsions of the hands and arms set in, followed by tonic convulsions and respiratory arrest. Cyanosis supervened rapidly, with trismus. An airway was inserted and artificial respiration with oxygen insufflation