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 CO_2 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 clysis. 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 Anaesthesia.* 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

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