

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<sub>2</sub> 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 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 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

started without result. This stage might have lasted between 1 and 2 minutes. Then suddenly the fingernails blanched, the pulse, which up to then had been full and slow at 60 per minute (normal rate 66-70) and apparently regular, become impalpable, and the face became greyish. While nikethamide was being prepared for injection, the heart region was slapped with a cold wet towel. After this slapping had been done twice the heart restarted, the colour improved, and the pulse became palpable and returned to its normal rate within a few seconds. Oxygen was administered by rhythmic compression of the bag and the patient's normal colour was restored immediately. Nikethamide was not required. Oxygen was continued for another five minutes. Recovery of consciousness was slightly retarded. There was a little retching, but no actual vomiting, and the patient was fully awake and dressed 20 minutes after all this had happened. He was kept in and observed for several hours and seen on frequent return visits. There were no after effects except for a slight headache within the first hour. . . .

"A child of 1½ years, coming to operation for inguinal hernia, premedicated with gr. 1½ of phenobarbitone and gr. 1/100 of atropine, was anaesthetised with nitrous oxide, oxygen and trilene, on the closed-circuit CO<sub>2</sub>-absorption unit. A rash appeared during induction, which was so unusual that I sent a messenger to the ward to ask the nurse if any rash was observed when she was washing the patient; she had seen none. The spots were scattered on the abdomen and chest and fairly symmetrical on the front of both thighs. There was no tendency for the spots to run together, as in an ether rash, except slightly on the thighs. It was maculopapular in type, slightly raised, and did not disappear on pressure; the colour was brighter

than that of an ether rash. On deepening the anaesthesia the rash disappeared gradually."

J. C. M.

MUSHIN, W. W.: *A New Circle Type Carbon Dioxide Absorber.* *Brit. Anaesth.* 18: 97-111 (Jan.) 1943.

"Over two years ago Messrs. Coxeter and Son Ltd. showed me an experimental model of a carbon dioxide absorber with ether vaporiser, possessing some interesting features, which were capable of improvement from the anaesthetist's point of view. As a result of our discussion certain essential requirements and other desirable, if not essential, features were agreed. In due course a new design based on this specification was produced and laboratory tests on an experimental model were made. These results were so encouraging that a clinical trial was made which confirmed in use the laboratory results." 2 references.

J. C. M.

AYRE, PHILIP: *The Anaesthetic Record.* *Brit. J. Anaesth.* 18: 180-184 (July) 1943.

"The present anaesthetic record and operation chart has been designed with strict regard to practical considerations, and represents an attempt to provide the maximum of essential information concerning the patient with the minimum of clerical labour: it is intended for routine use in hospital, including maxillo-facial, thoracic, neurosurgical and other 'special' clinics. It is compact (9½ inches by 8 inches) and contains sections for recording the pre-operative condition of the patient, anaesthetic agents and technique, a four-hour operation chart and a space for recording post-operative progress. . . . When filling in the anaesthetic record, it should be remembered that it is not the duty of the anaesthetist to make a complete clinical record of the