

ducing anesthetics by intravenous injection for surgical procedures of short duration. . . . The importance of pentothal sodium as a combat anesthetic cannot be overestimated. The mortality statistics with pentothal sodium are favorable and this agent appears to have warranted a permanent and enviable position among the anesthetic agents. . . .

"The use of local anesthetic agents in the spinal fluid to produce anesthesia dates back to the turn of the century. . . . In more recent years, with more skillful technique and more numerous new synthetic local anesthetic agents to select from, this type of anesthesia has received a new impetus and is at present enjoying much popularity. . . . Future researches are certainly to be directed toward the end of developing a better volatile anesthetic agent than ether. It appears indeed to be possible. Intravenous anesthesia needs to be made safer. Other agents need to be investigated further and better antidotes than are now available must be found. The future must investigate further and understand more clearly from the point of view of cellular physiology, what is meant by that profound hiatus in consciousness, so glibly referred to as surgical anesthesia." 6 references.

J. C. M. C.

MALLINSON, F. B.: *Modern (Non-volatile) Anaesthesia. Observations on 1000 Cases.* *Lancet* 2: 729-731 (Dec. 11) 1943.

"The patient's comfort and rapid convalescence, which should be the anesthetist's major care after safety, have been largely neglected until lately. Many anesthetists have thought that the only way to safety lies in adhering to the old and uncomfortable ways. Chloroform and ether are the chief offenders against the patient's comfort, and it is unsound to judge their safety

without following the patient's progress after leaving the theatre. Chloroform has already been widely discarded because of its toxicity, and evidence is quoted to show that ether is so toxic and so liable to produce post-operative pulmonary complications that it should also be given up. Nitrous oxide, pentothal and cyclopropane, combined with spinal or field blocks where deep relaxation is needed, can cover the whole field of surgery, including air-raid and front-line work. Inexperienced anaesthetists can acquire sufficient skill to be much safer with these modern methods than if they use chloroform or ether. In 1000 cases anaesthetised by modern non-volatile drugs the incidence of postoperative vomiting was only 20 per cent, and the total postoperative pulmonary morbidity was 0.8 per cent, compared with 11.9 per cent in a comparable gas-chloroform-ether series." 30 references.

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MARTIN, S. J.: *Current Considerations of the Army Anesthesiologist.* *New England J. Med.* 229: 893-898 (Dec. 9) 1943.

"The present-day military anesthetist is no longer the glorified medical technician of World War I, nor is he a superman of the present conflict. . . . According to the present scope of anesthesia per se, his primary obligations to his patient and surgeons concern adequate preoperative preparation; relief of pain; muscular relaxation, prophylaxis and therapy for adverse cardiorespiratory derangements during surgery; and prompt and effective post-operative care to prevent or minimize complications of circulation or respiration. In addition, he may be of some aid to the internist with the use of diagnostic or therapeutic blocks in treating peripheral vascular disease, the intractable pain of cancer, angina