longed anoxemia and shock in these cases account for a high mortality. . . . One of the early signs of fetal distress is a pronounced slowing of the fetal heart rate and convulsive activity of the baby during labor and should be recognized as an indication of anoxemia. If the heart rate should be increased beyond normal, subsequent severe asphyxia may be anticipated. Under such circumstances, inhalations of oxygen by the mother during the last several minutes of delivery and as long afterward as the cord pulsates will permit more oxygen and blood to reach the fetal circulation. Gentleness of manipulation and maintenance of body heat are two general principles of paramount importance in any resuscitation procedure followed from here on. . . . An outline of the immediate treatment of asphyxia neonatorum includes (1) gentleness in handling, (2) warmth, (3) aspiration of mucus, (4) oxygen inhalations, (5) artificial respirations by mechanical devices, (6) carbon dioxide at intervals and (7) drugs which stimulate the respiratory center."

J. C. M. C.

MINNITT, R. J.: *The History and Progress of Gas and Air Analgesia for Midwifery.* Proc. Roy. Soc. Med. **37**: 45–48 (Dec.) 1943.

"The fact that I had often noticed that although a patient undergoing teeth extraction with gas struggled violently, yet later had no recollection of the actual operation, encouraged the intention to try out the drug in midwifery, and early in 1933 I remember the late Dr. Howard Jones saying that he thought it could be administered on the injector principle. . . . On July 19, 1933, Mr. A. Charles King and I considered the adaptation of a McKesson oxygen therapy apparatus for the purpose, and during the next two months I collaborated with him in the construction of an intermittent flow apparatus for administering gas and air inhalations. . . . In order to enhance the value of analgesia, and for acquiring a transitory anaesthesia in suitable cases, other anaesthetic drugs can be combined with gas and air."

J. C. M. C.

LYONS, HAROLD, AND HANSEN, F. M., JR.: *Continuous Caudal Anesthesia in 200 Obstetric Patients.* Am. J. Obst. & Gynec. **47**: 105–110 (Jan.) 1944.

"Our study is based on a series of 200 consecutive obstetric patients in whom continuous caudal anesthesia was employed routinely in order to determine its practicability. In 5 instances, the anesthesia was unsatisfactory and inhalation anesthesia was used in the second stage. In 195, or 97.5 per cent of our cases, the method was successful. . . . A distinct advantage in this study was the fact that caudal anesthesia had been employed on our service during the second and third stages of labor in over 500 deliveries previous to the adoption of the continuous method, and we feel that a thorough fundamental training of the operator is necessary for its success. . . . Metycaine was used in all instances. . . . The equipment employed in this series was similar to that described by Edwards and Hingson. . . . The malleable stainless steel needle . . . is held in place with ¼-inch strips of adhesive tape. . . . When the cervix is completely dilated and the head is on the perineum, or when, in the judgment of the obstetrician in charge, the patient can be delivered within one hour without unwarranted interference, the caudal needle is removed and the patient then taken to the delivery room. . . . No obstetric complications which could be considered as contraindicating the usage of this procedure were encountered by us. The most important com-