

The baby was apneic and markedly cyanotic, but the heart was beating feebly about 20-30 times a minute. Immediate endotracheal insufflation of air was instituted. The baby began to breathe spontaneously about 30 minutes later. The infant was discharged from the hospital one month later and appeared normal for an infant of the age. A postmortem examination revealed the following positive findings: cardiac dilatation; passive congestion of the lungs with slight atelectasis of both bases; passive congestion of the spleen; and multiple small hemorrhages of the liver. A specimen of the bone marrow revealed the presence of sickle cell anemia. A specimen of the spinal fluid of this patient obtained at the postmortem was alkalinized with sodium hydroxide and shown to contain no meteycaine. . . .

"Continuous uterine pressure records were secured throughout labor in four patients. At the beginning of the experiment the uterine contractions were normal in type. . . . In two cases caudal analgesia did not modify the uterine contractions. In the other two patients the contractions became weaker, less frequent and longer in duration. . . . Between contractions relaxation became more complete as labor progressed." 10 references.

J. C. M. C.

Brown, A. E.: *The Use of Spinal Anaesthesia in General Surgical Practice*. Australian & New Zealand J. Surg. 13: 111-118 (Oct.) 1943.

"In the forty odd years since Barker introduced into English practice from Germany the use of 'Stovaine' by spinal injection, this type of anaesthesia. . . . has undergone many vicissitudes. . . . I now use it as a routine procedure in 50 per cent of all my operations. On the other 50 per cent, 16 per cent are performed with local infiltration methods, and 34 per cent of the whole with ether given by the

open method. General ether anaesthesia is reserved for young children, highly nervous patients, those 'immediate' operations in which there is not time for a proper premedication of the patient, Caesarean sections in which the premedication used may be expected to be harmful to the baby, and for those regions of the body which are regarded as being outside the reach of spinal anaesthesia. The last mentioned in my practice include operations on the breast. . . . The uncertainty as to level of the anaesthesia obtained and its duration was most noticeable during that period when 'Novocain' was the standard drug used. . . . Since the substitution of 'Percaine' for 'Novocain' as the active agent these eccentricities have disappeared. . . . In general, then, I would say that the use of spinal anaesthesia over the years has proved a very decided boon in my surgical practice."

J. C. M. C.

MADAN, K. E.: *Fatalities under Spinal Anaesthesia*. M. Press. 211: 43-45 (Jan. 19) 1944.

"The main thing that has prompted me to get this article published in a popular medical journal is the trial that took place by a general court-martial of a young English I. M. S. doctor in the Army in India who was charged with negligence and manslaughter, because, unfortunately, an English officer died after spinal anaesthesia. . . . I succeeded in clearing up all the points against the accused, and so he was acquitted of the serious charge of manslaughter. . . . In this particular case, 9.5 cc. of percaine (1-1500), which is a light solution, was injected in L₇/4 space, with patient in the lateral decubitus position. Only a few drops of cerebro-spinal fluid were allowed to escape, and no barbotage or expansion of fluid (i.e., withdrawing and mixing C-sp. fluid with the solution, and re-injecting) was done. Ephedrine one-

half gr. was also injected intramuscularly. The patient was immediately put in the Trendelenburg position, and after three-quarters of an hour he was taken back to his room. A feeling of faintness was complained of soon after the injection, but it quickly passed off and he was feeling well, but died three hours after spinal anaesthesia. The prosecution mainly alleged that he was left in his room without the head being kept low, the hypobaric (light) solution caused respiratory and circulatory failure by poisoning the medullary centres. . . .

"The post-mortem findings in this particular case were hypertrophy of the heart, and some fatty infiltration of the liver. The former points to some peripheral resistance to the circulation—sclerotic kidney, high blood-pressure, etc. The latter, though it may not be marked, interferes with the detoxification of the drug, and may therefore produce serious toxic effects even though the fatty infiltration may be slight. . . . Spinal anaesthesia is not well-tolerated by patients with high blood-pressure, and the kidneys cease secreting if there is a sudden great fall of blood-pressure. . . . I have observed no harmful effects in patients who, after operation, were kept flat, without blocks under the feet of the bed, even after high analgesia, whether by hypo, iso, or hyperbaric solutions. . . . The feet of the bed may be kept raised in cases where the blood-pressure is low. The reason for maintaining the Trendelenburg position after spinal is, . . . not to prevent diffusion upwards, but in the hope of preventing severe post-anaesthetic headaches."

J. C. M. C.

HINGSON, R. A.; FERGUSON, C. H., AND PALMER, L. A.: *Advances in Spinal Anesthesia*. Ann. Surg. 118: 971-981 (Dec.) 1943.

"Within the last five years spinal anesthesia has become the method of

choice in 30 per cent of our operative cases. Since January 1, 1938, we have performed 5150 spinal anesthetics in the United States Marine Hospital at Stapleton, Staten Island, New York. . . . The recent advances in spinal anesthesia; namely, (1) the principle of continuous spinal anesthesia, with an improved method of administration; (2) the addition of a more compatible supplement such as sodium pentothal; (3) more careful selection of cases for the procedure have greatly increased the benefits of this method for both the patient and the surgeon; (4) uniform results obtained with both long and short acting anesthetic agents in properly selected cases; and (5) partial withdrawal of unused and unfixed spinal anesthetics after operation permits more rapid return of physiologic nerve function. The incidence of success for this method varies directly with the skill and experience of the anesthetist. There must be recognized that a permanent hazard exists in the administration of this type of anesthesia. For our type of service, the advantages far outweigh the disadvantages, with the result that spinal anesthesia has become our most reliable method of surgical pain relief."

J. C. M. C.

COWAN, ELLEN B.: *Spinal Anaesthesia in Cases of Delivery by the Obstetric Forceps*. J. Obst. & Gynaec. Brit. Emp. 50: 433-436 (Dec.) 1943.

"The use of spinal anaesthesia in cases of delivery by the forceps has been found to be of benefit under certain conditions. The cases in which this method would be found to be advantageous are: 1. Deliveries following prolonged labour where there was 2nd stage delay and the patient was becoming exhausted. 2. Cases in which an anaesthetic had been already administered during the course of labor. 3. Cases of cardiac disease especially with an associated chest condition. 4. Cases