on the operating table in this series of cases, and there were no subsequent deaths that I attributed to the choice of anesthetic methods or agents. Entire intercostal paralysis did not occur except for transient apneas which were only rarely encountered during the induction of supplemental cyclopropane anesthesia. I believe that the intentional combination of spinal anesthesia with inhalation anesthesia has special merit in upper abdominal operations. Nausea and retching frequently occur in the conscious patient when spinal anesthesia is used alone. This is very troublesome to the surgeon and its control may require the use of inhalation anesthesia. The conscious patient is quite likely to complain of pulling sensations and discomforts which may be of reflex origin during manipulation in the upper abdomen. Spinal anesthetic doses sufficient to obliterate these complaints may be toxic and depressive. An unconscious patient, quiet breathing, relaxation that may be considerably prolonged beyond the expected effective time of spinal anesthesia with minimal amounts of inhalation anesthetics are, I believe, advantages which greatly facilitate upper abdominal surgical procedures.”

2 references.

J. C. M. C.


“Fractional or continuous spinal anesthesia is becoming more widely used in military surgery. . . . Except for the malleable needle the other items can be readily improvised. . . . The series of 25 cases . . . includes recurrent herniae, open reduction of the lower limbs, nephrolithotomy and appendectomies. . . . Procaine crystals were used. . . . It occasionally happens that spinal fluid cannot be aspirated after the patient has been turned on his back. Turning the needle 90 degrees often corrects the difficulty. If aspiration cannot be done, an injection can still be made, for the needle is very likely still within the spinal canal. Subarachnoid fibers within the spinal canal may cover the bevel of the needle.”

J. C. M. C.


“Intravenous anesthesia has now been proved to be as valuable as any other known anesthetic agent, including ether. In war surgery intravenous anesthesia, in its general usefulness, leads all others. The technique of administering intravenous anesthesia should be kept as simple as possible.”

19 references.

J. C. M. C.


“The belief that pentothal sodium in major surgery should be relegated to the status of a basal anesthetic or supplementary adjunct to another type of anesthesia is not well founded. . . . Pentothal sodium anesthesia is neither basal nor supplementary. . . . Pentothal sodium is adequate for major surgery in any case in which intravenous approach is feasible. Adequate preoperative medication will markedly improve the course of anesthesia. If the dosage is adjusted to the individual needs of the patient by fractional administration, pentothal sodium oxygen anesthesia has a wide margin of safety and can be used in many cases when other types of anesthesia are definitely contraindicated. The simplicity of the
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technic is an extremely valuable asset in those instances in which time and equipment are necessarily limited."

J. C. M. C.

NAMMACK, C. H., AND FINCK, MARY: Clinical Study of One Hundred and Sixty-five Cases in Which Sodium Ethylal was Used as an Hypnotic and Sedative. New York State J. Med. 44: 1124–1125 (May 15) 1944.

"The purpose of this study was to determine the hypnotic and sedative effects of sodium ethylal. This product offers the combination of a quick-acting and a slow-acting drug. . . . One hundred and sixty-five patients with varying diagnosis in the wards of the Fourth Medical Division, Bellevue Hospital, exhibiting many degrees of nervous and mental excitation, were given the drug, and its immediate, late, and later effects were studied. . . . It would appear from our study that in sodium ethylal one has a sedative and hypnotic that is effective in producing sleep rather promptly upon the administration of one capsule. . . . As in most medications of this type, the individual reactions of different patients vary, and it is doubtless a fact that a small number of patients may need a larger or a repeated dose. The duration of sleep would also be determined by the underlying disease, as those suffering from pain and respiratory embarrassment, such as the cardiaes, are more likely to be wakeful than the other patients. While a number of the patients were moderately drowsy the following day, none presented any evidence of mental confusion, 'hang-over,' or other untoward symptoms." 12 references.

J. C. M. C.


"At the Battalion Aid Station very little surgical treatment is available. . . . A limited supply of ether and ethyl chloride and some procaine and epinephrine tablets for preparing a solution of local anesthesia are available. It is amply supplied with morphia. Since it is generally believed that severe pain is one of the factors producing primary shock, the importance of controlling pain at the earliest possible opportunity cannot be overemphasized. This may be accomplished by intravenous injection of morphine sulphate. . . . Additional comfort may be obtained for the casualty by the judicious use of local or block anesthesia. Intracaine has an anesthetic action of approximately three hours. It has the most prolonged action of any of the safe local anesthetics and is compatible with the sulpha drugs. . . . The first opportunity for definitive surgical treatment arises when the casualty is brought in contact with a mobile surgical unit or the Evacuation Hospital. . . . The selection of the anesthetic agent to be used in the combat zone is influenced by numerous factors. Supply facilities make it essential to eliminate everything except bare necessities. In the fixed hospitals, adequate choice of agents and methods is usually possible. . . . Proper treatment of shock prior to starting an anesthetic for a major operation is essential. . . . In general, it is preferable to use an anesthetic agent that will not delay evacuation of the casualty, and one from which recovery of consciousness is rapid. The utilization of a room where unconscious postoperative cases can be segregated until it is safe to leave them alone will assure more efficient care during this period and conserve personnel. Essential equipment, such as suction apparatus, carbon dioxide, oxygen, air ways, stimulants, etc., should be kept available in this recovery room.