
"The writer will introduce only seven of the bugbears which have worried him from time to time, and ... will suggest in each case procedures which have been recommended by recognized authorities in the field of anaesthesia. ... Emergency anaesthesia cases frequently occur soon after meals. The danger, of course, lies in the possibility of inspiring into the airway pieces of vomited food. ... A safe precaution in any type of case where the stomach contains food, is a gastric lavage prior to the anaesthetic, and the use of full or partial Trendelenburg position whenever the airway indicates the need of outward drainage. The lateral position with head lowered is never amiss in anaesthetizing children and is particularly good in the above circumstances, or in the presence of an 'excess mucous discharge in the throat, or as routine, following tonsil and adenoid operations. ... The anaesthetist must give real consideration to the possible effects of existing chronic nasopharyngitis, nasal sinusitis or tonsillitis. The bronchial mucus of smokers is frequently very thick and tenacious and some of it may be removed even before the patient receives the preoperative medication. The reaction of the patient to the preoperative dose of atropine or hyoscine, and the length of the operation also become factors in the case, for it may be necessary to repeat the drug during the operation. ... Bronchoscopic suction through a catheter is one of the more recent important procedures in the prevention of pulmonary tract complications, and particularly of atelectasis. Where there is any suspicion of an obstructing secretion that is not being expelled by respiratory effort, suction should be instituted promptly. ... If ordinary suction used peri-

odically throughout can avoid the necessity for major bronchoscopic su-
tion, so much the better. The periodic use of full or partial Trendelenburg posture for drainage from the respira-
tory airway when indicated, offers the anaesthetist one more arm with which to fight. A recent suggestion with regard to possible bronchial complications is worthy of consideration. It recommends in thyroidectomy the use of one of the sulfonamides for three or four days prior to operation as a prophylatic to post-operative pulmonary infection or tracheitis. ..."

"There can be no doubt that the skilful administration of pre-medication for its proper sedative effect and for the control of undue respiratory tract secretions reduces the amount of anaes-
thetic drugs required and thereby reduces the chance of toxic pulmonary complications. ... One of the 'un-
kindest cuts of all' is the practice of dragging terror-stricken children to the operating-room for tonsil and adenoid operations while they may be screaming and struggling to free themselves from the clutches of their captors. Among various preoperative sedatives in such cases, the anaesthetist will do well to consider the value of sodium pentothal given in the ward per rectum through a small catheter, and in a solution of one ounce to one and one-half ounces of water, containing 1 mgm. for each 50 pounds of body weight. It is my experience that when the preoperative sedation is insufficient, and particularly when barbiturates have been omitted, the sudden drop in blood pressure seen in intraspinal anaesthetics, is more apt to occur. ... Not a few patients have preconceived prejudices with regard to intraspinal anaesthesia, usually arising from ill-considered comments of other physicians or through those 'Job's com-
forters' whose chief delight in life appears to be to alarm their sick friends. It is better not to insist upon
spinal anaesthesia in such cases. . . .
A partial postoperative Trendelenburg position for eight hours is always desirable, when surgically possible, as a preventive to real headache. . . . When the intraspinal anaesthetic begins to wear out before the surgeon has finished his work, the anaesthetist’s worry begins. . . . Prompt use of intravenous morphine and atropine is suggested, and, if necessary, start a gas general anesthesia, and do so early. . . . Let it be urged that when a supplementary anaesthetic is likely to be needed anticipate the need and give it early. Nausea and vomiting in intraspinal anaesthesia alone demand continuous inhalations of 100% oxygen, and then, if it persists, cyclopropane or nitrous oxide to stage one or stage two of anaesthesia, will usually suffice to control it. When an abnormal fall in blood pressure does not respond promptly to vaso-constrictor medication, it signifies a commencing and rapidly increasing anoxaemia. . . . Hence, when there is any doubt, add volume to the blood, using 5% glucose in saline solution intravenously, and then, if still in doubt, give a transfusion of blood or plasma, or both. . . .

"The anaesthetist should remember that the prolonged or exaggerated Trendelenburg position is undesirable for all patients, and definitely harmful to obese patients. . . . The anaesthetist is always well-advised to have attached to his apparatus a Horton’s resistance coil with all its contact chains properly placed during the administration of the gas [cyclopropane]. Whether this procedure is fully protective or even partially protective against static or electric spark, I will not undertake to offer any assurance. However, it is certain that it is presently accepted by recognized authorities in anaesthesia as the only expedient yet devised, and in a court of law it would prove a valuable asset to an anaesthetist if he happened to be the party on the defence. . . . The sudden rise in the pulse rate and elevation in blood pressure in toxic goitre operations appear usually coincident with the manipulation by the surgeon of the thyroid gland’s first lobe after its exposure. Sometimes the anaesthetist is accused of causing the offence. The anaesthetist is not required to carry blame that belongs elsewhere or nowhere; but at the moment this crisis presents itself he should consult with the surgeon, and together they should decide forthwith how much farther the surgeon is justified in proceeding with the operation. . . . The anaesthetist must constantly keep in mind that all prolonged anaesthesia, even in healthy patients, causes definite and rapid falls in plasma proteins, and that this is particularly significant in surgery upon the gastrointestinal tract, the biliary tract, or in toxic goitre. The functioning ability of the liver because of its relation to the adequate supply of plasma proteins is always important respecting the patient’s preparedness to undergo major surgery. Someone has said that the best treatment of shock is prevention. Hence, the importance of the anaesthetist knowing in advance the patient’s sufficiency in plasma-proteins and liver function to withstand the test the operation is likely to demand."

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