billion dollars spent in 1941. He doesn’t mind spending money in keeping it up but complains when he has to spend money on the upkeep of the human motor.

“The University of Texas health program is rapidly being expanded . . . and we feel we can solve our State problems better than the Federal Bureaus, without an expensive administrative staff.

“The Public School health programs can also be enlarged. The factor of State rights is involved in our own local administration of charities.

“Insurance including hospital and surgical services, carried by private Insurance Companies operating under existing Companies of ‘Free Enterprise,’ offers a type of protection in which the patient has free choice of physician and hospital.

“Enlargement and improvement of established charity clinics and hospitals can be accomplished locally where needed.

“When public money is spent, let us spend it in research laboratories, hospitals, and schools, instead of on cold monuments, a new museum, or on some useless leaf-making project. American youth will thus be benefited for future generations. Let us . . . look to improvement for future generations.

“Lasting progress comes slowly as a tree grows, not through drastic laws and deeds.

“Let’s keep the doctor American!”

P. M. W.

LORCHAN, P. H.: Recent Advances in Anesthesiology. J. Kansas M. Soc. 45: 318–326 (Sept.) 1944.

“The medical anesthetist has assumed additional duties besides his principal function as the administrator of pain obviating agents during surgery . . . In the field of inhalation anesthesia . . . there have been no important developments in recent years. . . . Trichlorethylene has been used with success in the British Isles and is still confined to hospitals with well-organized departments of anesthesiology. Cyprome and cypreth ether are still in the experimental stages and offer great expectations at the present time. . . . The intravenous anesthetic agents, evipal sodium and pentothal sodium, are now being used more frequently, especially with the impetus given to the method by its use in the military forces . . . Spinal anesthesia is a safe procedure in the hands of the trained anesthesiologist who understands its capabilities and respiratory depression which may occur. . . . Continuous spinal anesthesia is supplying a great need to the surgeon and anesthesiologist in the prevention of spinal fatalities . . . The introduction of continuous caudal anesthesia is one of the most important developments of anesthesiology during the past few years. It seems to be answering a real need in obstetrical procedures. . . . Regional nerve block anesthesia is especially indicated in feeble patients and patients in shock . . . The employment of absolute alcohol for the relief of intractable pain is highly recommended when other measures have proved futile or undesirable. When sympathetic pain or causalgia is suspected, blocking the sympathetic nerve supply to the painful area with a local anesthetic solution is of diagnostic value. . . . The well-trained anesthesiologist will assist the surgeon in the prevention of cerebral and cardiac anoxia by the proper utilization of oxygen therapy. . . . The anesthesiologist, due to his knowledge of the use of gases, has utilized the use of the inert gases such as helium and nitrogen in the medical patient . . . As the anesthesiologist frequently encounters respiratory depression as the result of the anesthetic drugs during surgery, it is no more than proper that the pa-
tient who has a marked respiratory depression as the result of an overdose of barbiturates should have the service of a qualified anesthesiologist. . . . For the obtaining of sufficient muscular relaxation under anesthesia, the anesthesiologist frequently uses the nerve paralyzing drug curare."

J. C. M. C.


"In spite of the discovery of many new drugs and the development of many new anesthetic techniques, mortality statistics remain unsatisfactory. In 1921 there were 347 deaths reported to the coroner; in 1931, 723; in 1941, 835. It will be shown that all modern anaesthetic agents have their special value, their dangers and disadvantages; that it is the man and not the machine or the method of administration which is of primary importance. . . . Ether remains pre-eminently the best anaesthetic. . . . Vinesthene is a powerful anaesthetic, non-irritating, pleasant to inhale and has little after-effect. . . . In an investigation as to the chance of recovery after respiration had ceased and artificial respiration was instituted (in dogs), vinesthene was found particularly satisfactory. . . . Vinesthene would appear to be greatly superior to cyclopropane as regards safety, absence of after-effects, and the muscular relaxation obtainable. . . . A purified preparation of trichlorethylene, known as trilene (I.C.I.), was introduced by Hewer and Hadfield. . . . Convulsions have been noted, but these ceased spontaneously. One important warning is necessary: trilene must not be used in a closed circuit system, as cases of cranial nerve palsies and of deaths ascribed to poisonous substances produced by the interaction of trilene and the soda lime of a carbon dioxide absorber have been reported. Dis-
turbances of the cardiac rhythm and rapid breathing have been noticed. . . . The introduction of cyclopropane marked an important epoch in the development of anaesthesia, but certain disadvantages associated with this anaesthetic have become apparent. . . . Erythema and other examples of allergic reaction to the anaesthetic have been reported, but the addition of helium to the anaesthetic mixture is thought to assist in avoiding difficulties. Cardiac irregularities are not uncommon, and slowing or irregularity of the heart is a warning sign. . . . A condition called 'cycle shock,' occurring some hours after administration, has been noted, and it is now acknowledged that circulatory collapse and complications are more frequent after cyclopropane than after ether. Vomiting appears to be as frequent as after ether. Explosions have also been reported. In spite of these disadvantages, cyclopropane is an extremely valuable agent, as Taylor shows in reporting on 41,690 cases, but he says that it is not recommended as the agent of choice unless it is administered by an anaesthetist well trained in its use. . . . It cannot be maintained that local anesthesia is entirely without risk, and deaths have been reported in the lay press and in the medical literature. There appear to be two forms of fatal reaction:—convulsions and sudden collapse. . . . Some local anaesthetic agents are more dangerous than others, cocaine being the chief offender. . . . The pre-operative use of barbiturates is valuable, but it has been noted that although these drugs protect against convulsions when given fifteen to thirty minutes before procaine, they give no protection against sudden collapse. . . . Premedication should begin the night before operation by ensuring a good night's sleep, and this can usually be achieved by the administration of phenobarbitone, 1