

Outlet forceps are usually necessary, but because of the excellent relaxation, I have found lacerations and extensions from episiotomies less frequent with caudal analgesia than with other forms of anesthesia. . . . Fetal distress, presumably due to anoxia, has been reported when the maternal blood pressure goes below 90 systolic. . . . I am always afraid that the tip of the needle may move when the mother turns over or is transferred from the bed to the delivery table. Several times I have seen evidence of intravenous spill when an injection was given just after the patient had been moved. . . . The use of continuous caudal analgesia has been attempted in Durham in 100 cases. These cases represent the beginning efforts of ten different people. . . . A third of our cases were failures. . . . In spite of our inexperience, clearly demonstrated by the high percentage of failures, there were no serious accidents due to caudal analgesia. . . . There were 4 fetal deaths and 1 maternal death from causes unrelated to the caudal analgesia. . . . There was one broken needle, which was easily recovered. . . . Lull and Irving have noticed decreased perineal damage in their patients. I agree with this finding and believe also that there is less cervical damage. Unfortunately the method works best for those who need it least—the normal patients who are having rapid, uneventful labors.” 7 references.

J. C. M. C.

CUNNINGHAM, II. A.: *Caudal Anesthesia*. Wisconsin M. J. 43: 931-934 (Sept.) 1944.

“Many warnings have been voiced by authors each representing a newer or at least a different mode of attack to the problem of caudal anesthesia. . . . The charge of selecting the work is accepted because caudal is not a routine procedure, only 27 per cent of the work being done by this technic. [133 pa-

tients.] In view of the many successful genito-urinary blocks, there is little reason to doubt that these can be transferred to obstetric work. A single injection caudal has proven its worth. A continuous injection caudal is beyond our scope. The equipment we use is simplicity itself—the Lundy-Labat syringe and caudal needle. When the opportunity presents, we infiltrate the skin, but it is not always necessary. Otherwise, one closed syringe and one needle are used—contamination is at a minimum. The material used is 1.5 per cent metycaine, but 2 per cent procaine is just as satisfactory. No ephedrine is used. We have used roentgenology and dissection to demonstrate the equipment and amounts of solution required. Thus far, clinical results bear out these findings. I do not believe that the obstetrician has either the time or the inclination for this work.” 15 references.

J. C. M. C.

THOMAS, R. C.: *Caesarean Section under Spinal Analgesia*. J. Obst. & Gynaec. Brit. Emp. 51: 324-329 (Aug.) 1944.

“We recently published the records of 121 Caesarean sections performed under spinal analgesia. . . . Since the previous article was written, we have continued to use heavy Nupercaine as the anaesthetic of choice for the operation of Caesarean section, and we now record a further 82 sections carried out under spinal analgesia induced with this solution. . . . There has not been a maternal death due to the anaesthetic, or a maternal death under the anaesthetic from any other cause whatever. . . . The overall maternal mortality is . . . 0.98 per cent. . . . Our confidence in heavy Nupercaine . . . as a safe and suitable drug for use in spinal anaesthesia in selected cases of advanced pregnancy remains unshaken.”

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