GILLESPIE, N. A.: *Factors which Influence Success in the Administration of an Anesthetic.* Ohio State M. J. 45: 25–33 (Jan.) 1945.

The author begins by defining a successful anesthetic administration and points out that patients and surgeon may have different criteria of success. The good anesthetist attempts to satisfy both without compromising his own criteria of success.

The factors which influence success are divided into personal and technical. Under the first heading is discussed the importance of personal contact with the patient, and of humanity in dealing with him. The relation of anesthetist to surgeon is discussed with particular emphasis on the ethics of consultation and the need for professional courtesy. The author believes in meticulous punctuality and in minute attention to detail in the care of his apparatus and equipment—he advocates that these "minor chores" should be performed by the anesthetist himself. The ability to reach decisions is stressed.

Preliminary medication is discussed as the first of the technical factors; and the author points out the importance of allowing the anesthetist to determine the drug to be used, its quantity, and its timing. He declines to discuss the anesthetic agents because he feels that their properties are less important than the skill and judgment with which they are used. Instead he points out that the chief dangers of anesthesia—hypoxia and hypercarbia—can easily occur regardless of agent or technic used. He describes the signs of these conditions and discusses their prevention and treatment. A plea is made for more accurate records of the patient's condition; before, during and after anesthesia. Stress is laid on the methods of statistical analysis recommended by the Committee on Records and Statistics of the American Society of Anesthetists. The paper ends with a plea that as anesthetists we strive for nothing less than perfection.

A. L.

STODDARD, C. C.: *Anaesthesia as Practised on Active Service in the Navy.* Canad. M. A. J. 51: 409–412 (Nov.) 1944.

"The practice of anaesthesia in our naval base hospitals does not differ markedly from that in civilian institutions so far as agents and techniques used are concerned. . . . Survivors were brought into our hospitals suffering from burns, exposure, dehydration and injuries from torpedo and depth charge blasts. Many were in critical condition and needed the utmost in medical, surgical and anaesthetic management. After being in hospital a few days many lost their nerve, would not sleep and dreaded any proposed operative procedure. Large doses of sedatives had very little effect except to depress or excite them. Cyclopropane and intravenous pentothal sodium were anaesthetic agents used with gratifying results to all concerned. Due to the nervous state of these patients local and spinal anaesthesia were contraindicated. Generally speaking, heavier premedication is required than for people in civilian life. . . . During the past year and a half 2,117 anaesthetics have been administered by the Department of Anaesthesia at the Royal Canadian Naval Hospital at Halifax. . . . There were also 938 local anaesthetics administered by the surgeons. Spinal anaesthesia was used in all intra-abdominal surgery unless contraindicated. . . . Pentothal sodium intravenously has become one of our most useful and safe anaesthetic agents. . . . In our series of 700 administrations there was one case of severe laryngospasm in a thick-necked individual who did not have

any atropine preoperatively. Another case required controlled breathing and coramine for about four minutes due to an overdose. . . . One is impressed by the number of ratings returning from overseas who request pentothal sodium anaesthesia. During a nine-month period in 1943, cyclopropane was administered in 40.28% of all inhalation anaesthetics; cyclopropane and ether in 29.17%; nitrous oxide, oxygen, and ether in 30.55%. Endotracheal anaesthesia was used in 41.66% of cases. I consider cyclopropane as one of our best choices as an anaesthetic agent in shock or potential shock cases. . . . Ether was added when adequate relaxation of the abdominal muscles could not be accomplished by cyclopropane alone. A switch to ether was made when cardiac irregularities occurred and did not disappear on lightening the anaesthesia. Ether was also used in operations of the ear, nose and throat. . . . Local and regional nerve blocks comprised 5.23% of all cases. . . . We were somewhat disappointed with the number of requests for diagnostic and therapeutic nerve blocks. . . . Oxygen therapy, resuscitation and intravenous therapy is supervised and controlled by the Department of Anaesthesia. . . . At sea, local, spinal and intravenous anaesthesia will take care of the usual types of cases. For the untrained anaesthetist ether by the open drop method or Oxford vaporizer will be the anaesthetic agent of choice for major surgery in the severely injured at sea." 7 references.

J. C. M. C.

SAKLAD, MEYER; SAKLAD, ELIHU, AND SELLMAN, PRISCILLA: *Anesthesia for War Surgery.* Connecticut State M. J. 8: 735–743 (Nov.) 1944.

"The problems of transport prohibit the use of many anesthetic agents and apparatus, particularly in advanced areas, so that the dependence must be placed on a few easily transportable drugs. . . . Since the influx of casualties may be rapid, the necessity of treating large numbers of wounded in a short space of time limits the anesthetist to simple and effective procedures. . . . Shock is, of course, a serious factor in war casualties. . . . Advanced sepsis should have a definite influence upon the choice of anesthesia. Septic patients do not tolerate anesthesia well. . . . In advanced areas where minimum equipment is available and where a limited amount of surgery can be performed, shock therapy and the relief of pain are paramount measures. The greatest single aid in the relief of pain is morphine, but this drug has a serious drawback in its depressant effect on respiration. . . . Chloroform has little if any place in civilian anesthesia, but in war surgery the demand for it outweighs the pharmacologic disadvantages. . . . It is best given by slowly dropping upon a wire mesh mask not too thickly covered by gauze. In spite of all that has been claimed for the intravenous barbiturates in the medical, lay and commercial press, they have no place in the treatment of patients suffering from active or incipient shock. . . . Procain (novocain) has a vital role in anesthesia in advanced areas. . . . The greatest single advantage of the barbiturates in advanced areas is associated with regional anesthesia in the treatment of procaine reactions. . . . The fire hazard presented by ether and the bulk it occupies, in addition to the difficulties encountered in induction, may prevent the use of this agent in advanced areas. Airways, both oral and nasal, should always be at hand. . . . For anesthesia in intermediate areas one may reasonably expect to have agents, methods and conveniences not available in forward areas, although not to the same