

ical problem of anesthetic agents and hemorrhagic and/or traumatic shock. One wonders if direct observation and measurement of retinal vessels following a bloodless phlebotomy with the use of tourniquets on all four extremities in the anesthetized control, partially hemorrhages or traumatized case, would not reveal analogous results seen in dogs.

In conclusion, I should like to express my gratitude for the pleasure of commenting on this very stimulating paper. While emphasis has been given essentially to the peripheral vascular phenomena of one type of shock, namely that due to hemorrhage, it has been clearly pointed out how seriously the margin of circulatory reserve

may be affected by the choice of an anesthetic agent employed for surgery in such cases. The authors have therefore paved the way for a more rational approach to the anesthetic management of shock in civilian and military casualties undergoing surgery. And this is indeed a timely contribution.

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*Editor's note:* This is an extract of a more lengthy letter received by the Editor based upon the full discussion by the writer after the presentation of the article commented upon.

#### To the Editor:

The March, 1945, issue of the News Letter of the American Society of Anesthesiologists contained a statement to the effect that a precipitate is formed when pentothal sodium and Intocostrin solutions are mixed, that the precipitate contains no active material, and that this precipitate had not been previously reported in the literature. The May issue of the News Letter contained a correction, stating that "the precipitate is the barbiturate." Dr. John Brody, in the May, 1945, issue of ANESTHESIOLOGY, mentioned the formation of the precipitate and added, "A survey of the recent literature on curare and pentothal sodium did not reveal any report of this phenomenon."

I should like, therefore, to quote from my article, "The Use of Curare in Anesthesia; A Review of 100 Cases," which appeared in the January, 1945, issue of ANESTHESIOLOGY, preceding these various letters:

#### To the Editor:

In a recent issue of ANESTHESIOLOGY, Knight (The Use of Spinal Anesthesia to Control Sympathetic Overactivity in Hyperthyroidism, ANESTHESIOLOGY 6: 225-230, May, 1945) brought to our attention a valuable therapeutic tool in the treatment of thyroid crises. However, I believe that we must at least entertain an alternative explanation concerning the mechanism by

"A note of warning would not be amiss at this point for those who administer curare to a patient receiving pentothal. In the first place, as has been described, pentothal has a slight curariform action of its own. Secondly, two respiratory depressants are being used simultaneously. Finally, if the same intravenous needle is used for the administration of both agents, probably a common procedure, a precipitate is formed, which is always produced when pentothal is added to an excess of curare (Intocostrin or d-tubocurarine chloride), which conditions are present when curare is given in this manner; the precipitate seems to be soluble in an excess of pentothal solution and possibly in plasma and appears to be precipitated pentothal.

Very truly yours,  
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which spinal anesthesia helps these patients. To be more specific, is it not possible that a complete interruption of sympathetic impulses follows the induction of sensory spinal anesthesia up to a level of the fourth or fifth thoracic segment? The answer to this problem depends on whether or not the sympathetic fibers in the subarachnoid space are susceptible to a lower concentration of procaine than are