Intravenous anesthesia in a safe depth does not produce the desired anal muscle relaxation. Inhalation anesthesia must be produced with strong concentrations of potent agents to secure the operative conditions in this area comparable to those produced by the local agents. Such deep stages of general anesthesia are frequently followed by an unpleasant recovery. Infiltration of the operative site is hazardous due to the inevitable bacterial contamination of this area. . . . Without a doubt the safest form of anesthesia for . . . [areas about the face] is local infiltration of the operative site, or a nerve block if practical. . . . Under any type of general anesthesia the great worry and responsibility of the anesthetist is to be able to maintain an adequately patent airway. . . . It is therefore necessary during operations under general anesthesia on the nose and mouth, and preferable for all long operations about the head, for an intratracheal tube to be inserted."

J. C. M. C.

WYLIE, W. L.: *To What Extent Should Anesthesia be Used in Operative Dentistry?* J. Dent. Education **9**: 120–124 (Dec.) 1944.

"Inauguration of selective service in 1940 gave wide publicity to a condition by no means unknown to the dental profession and to other organizations concerned with public health—the widespread prevalence of dental caries along with the comparatively narrow spread of service intended to prevent or correct the malady. Investigations previously made by the United States Public Health Service had shown that approximately twenty-two per cent of the people of our country receive regular dental care. Of the remainder it has been estimated that fifty-eight per cent can afford to pay for part or all of such service and that twenty per cent can afford to pay nothing. Of that large percentage able to pay for part or all of their work but receiving none it is said that the force lacking is a motivating or educational one. . . .

"Were the educational or motivation view entirely sound the results of selective service examinations should have lent conviction to the argument. With the universal use of radios there are few homes of the land which for years have not received the daily admonition to 'clean your teeth as your dentist does and see your dentist twice a year.' Local dental organizations with the aid of the Public Relations Bureau of the American Dental Association have long been engaged in spreading the gospel of dental care. In addition there have been the earnest and more or less effective efforts put forth through the public and parochial schools and through child health organizations. Yet with all this educational impetus, the trouble marches on. . . .

"The contention, which some social workers advance, that the problem is one almost wholly chargeable to indigence is disproved by the fact that the people concerned in some way manage to satisfy those wants that run strongly in the direction of luxuries. . . . Valid as both reasons cited may be with limitations, there is one factor not sufficiently stressed that contributes perhaps more than either to the low percentage of dental care received by our people. The fear of pain in the dental office is traditional. . . . Part of our educational effort might profitably be directed toward the banishment of that fear. . . .

"I see no good reason why the use of an anesthetic in cavity preparation should not become a matter of routine procedure in the clinic rather than the exception to the rule as has been the case heretofore. . . . The general adoption of anesthetics for use in operative

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work, particularly by students, may be condemned because lack of the warning signal of pain may encourage injudicious and hasty cutting that may prove injurious to the pulp, either through exposure or from the generation of heat through pressure or too rapidly revolving burs or stones. A student who will cut too deeply into a tooth under an anesthetic is almost as likely to make the same mistake without it. . . . As to injuries resulting from overheating due to the friction of revolving engine instruments, there need be no occasion for such trouble if approved methods of cavity preparation are followed. . . .

"The anesthetic of widest general use in dentistry is undoubtedly novocaine. It is used to the exclusion of all other anesthetics in cur operative work, except as some one of the topical type may be used occasionally on an experimental basis."

J. C. M. C.

PAPPER, E. M.: *Anesthesia for the Burned Patient.* Surgery 17: 116–121 (Jan.) 1945.

"In the postoperative period several observations of interest were made by way of comparison of the various anesthetics employed. There was no apparent difference in the success of viability of the graft with regard to the anesthetic employed. There was no significant change in the hematologic picture of the four patients anesthetized with spinal and regional techniques. There was a moderate depression of both red blood count and hemoglobin in the patients anesthetized with pentothal sodium, requiring an average per patient of one whole blood transfusion consisting of 500 cc. in the immediate postoperative period. The patients anesthetized with ether exhibited a more significant anemia postoperatively, requiring on the average three blood transfusions of 500 cc. each in a similar period of time. It should be mentioned that transfusion was given to all patients until the red blood count had reached a minimum of 3,500,000 per c.mm. with a proportionate concentration of hemoglobin. It is evident, therefore, that in patients in whom general narcosis was considered necessary for skin grafting procedures in the treatment of burns, the pentothal sodium nitrous oxide sequence exerted a less harmful effect upon the final picture in the peripheral blood than did ether.

"Some light is cast upon the present controversy concerning the concurrent use of sulfonamide drugs and barbiturate anesthesia. All patients observed were given one or more drugs of the sulfonamide group preoperatively and immediately postoperatively. No demonstrable ill effects were noted in the patients anesthetized with pentothal sodium and no synergism between the two was seen. In fact, as pointed out the course subsequent to operation in the patients anesthetized with pentothal was, on the whole, more benign than that of the etherized patients, despite the use of sulfonamide preparations. The present practice at this hospital is to utilize sulfonamide drugs, regardless of the type of anesthesia to be employed, prior to operation upon the burned patient.

"There were no deaths in this series of burned patients subjected to skin grafting procedures. . . .

"For pain relief the administration of morphine is probably the least harmful and the most satisfactory method of analgesia. Where necessary, small doses of pentothal anesthesia or ether anesthesia may be considered acceptable. . . . The employment of spinal anesthesia, particularly if the areas involved are above the tenth thoracic segment, is of considerable danger in the acutely burned patient because of the attendant circula-

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