tory depression produced by this type of anesthesia in the patient whose circulation is already impaired, either actually or potentially."

A. W. F.

Thoracoabdominal Wounds. Bull. U. S. Army Med. Dept. No. 85: 12 (Feb.) 1945.

"The management of abdominal and thoracic wounds has long been a challenge to surgical skill and judgment. . . .

"If an abdominal approach is used when perforation of the diaphragm may be present, it is essential to have an intratracheal tube in place. The sudden collapse of a lung from a sucking diaphragmatic perforation has been observed to cause death on the operating table."

A. W. F.

ROVENSTINE, E. A.: *The Pre-anesthetic Preparation of the Surgical Patient.* J. Michigan M. Soc. **44**: 45–51 (Jan.) 1945.

"It is no new practice to give drugs shortly before anesthesia is induced. . . . The modern concept, however, except as related to surgical preparation, has gained little significance. This tardy recognition has been the result of the empirical use of pre-anesthetic drugs and the convenience of routinizing practices. The time-honored 'quarter and one hundred fiftieth' has become so firmly intrenched that it is almost traditional in many clinics. . . . Once a routine is established the incentive for improvement is suppressed. . . .

"Pre-anesthetic medication has for its primary purpose an increased margin of safety for the patient. His comfort and rapid convalescence are other important aims. . . . It is established that patients who have received sedative drugs will require correspondingly less anesthetic agent depending upon the degree of narcosis already present. . . .

"The thesis of Guedel is familiar wherein he correlates the reflex irritability or what might be termed resistance to anesthesia directly with oxygen demand or metabolic activity and indirectly with the state of mental activity. . . . In practice this tenet serves as a useful guide in the proper pre-anesthetic medication. To illustrate, patients with elevated metabolic rates, such as those with hyperthyroidism or infections, can be given properly a much larger amount of sedative drugs than is needed or is safe when there is a normal metabolic rate. Likewise for the old and young, a decreased amount of sedatives is imperative and can be approximated from Guedel's recommendations. . . . Other considerations are the anesthetic agents and techniques that will be employed later, the nature of the surgery to be completed, the postoperative requirements and, of greatest importance, the nature of existing disturbed functions that may influence either the response to pre-anesthetic or anesthetic drugs. . . .

"The opiates have a well-deserved place at the top of the list of drugs for use immediately before surgical anesthesia is induced. The morphine salts are representative and most widely employed. The profound analgesic effect of morphine is advanced to justify its use to control pre-anesthetic pain. It is readily agreed that such use is indicated but it should be remembered that there are other methods to control pain and secure comfort. Among these are nerve blocking, nursing care, freedom from worry and fear and other analgesic drugs. . . .

"The objective and subjective depression with morphine does not parallel the analgesic action. When given subcutaneously, more than an hour will elapse before subjective narcosis

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