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"To determine more accurately the effect of caudal analgesia upon the uterine contractions, the labors of 50 patients under caudal analgesia were studied by means of the Lóránd tocograph, an instrument devised for recording graphically the contractions of the uterus through the anterior abdominal wall. . . . The records of uterine activity under caudal analgesia were made between November 8, 1943, and April 8, 1944, upon 50 women in labor from the ward services of the Philadelphia General Hospital and the Kensington Hospital for Women, Philadelphia. . . . Of these patients 33 demonstrated no significant change in either strength or frequency of contractions. In 9 patients the contractions were interrupted for periods of 30 minutes to 2 hours. Six patients exhibited a decrease in frequency of contractions, and 1 a noticeable decrease in the strength of the contractions. Two patients showed significant improvement in both the strength and frequency of contractions. . . . Of the 50 patients studied 27 showed no change in uterine tone during analgesia. However, 22 patients exhibited a progressive decrease in tone, and 1 exhibited a marked rise in tone. . . . The most important factor determining the effect upon the uterine motility was the level to which the analgesia ascended. When the recommended level (between the 6th and 10th thoracic segments) was maintained, only 20 per cent showed any decrease in uterine motility, and these were very minor changes. The remainder were unaffected. When the level of analgesia was permitted to ascend above the 4th thoracic segment, 69 per cent of the patients had their labors interrupted. When a low level of analgesia involving only the sacral nerves was achieved in 2 patients there was a marked improvement in the strength and frequency of the uterine contractions. This improvement continued after relief from pain was attained. Forty-four per cent of patients studied showed a progressive decrease in uterine tone. This did not appear related to the level of analgesia." 13 references.

J. C. M. C.

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"From a purely medical standpoint the relief of pain in normal labour presents no great difficulty if we are prepared to spend many hours sitting beside the beds of women in labour and giving them our chosen form of analgesia. . . . We are not, and we cannot, at present, be prepared to spend the time and the money which such a proceeding would entail. We have then to take a practical view, that is—what can we do with the facilities which are at our disposal? . . . In the early stage of labour some sedative drug should be administered. This is to be followed by gas and air analgesia, which can be relied upon to give adequate relief in 80 per cent of all cases and can be safely left to the midwife's care. Where the practitioner himself is present, gas and oxygen or trilene and air analgesia do each give absolute complete relief from all pain. Technical difficulties stand in the way of their everyday use. For the obstetric operations encountered in general practice, either from the Oxford vaporiser or an open mask remains the anaesthetic of choice where there is danger of fire. If this risk is present chloroform is a satisfactory and safe anaesthetic if due precautions are

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