taken and the anaesthetic is skilfully administered. The success or failure of any method of producing anaesthesia or analgesia depends on the skill and experience of the administrator, not on the chosen drug or method of administration. There is a great gulf fixed between midwifery conducted in teaching hospitals and special centres of research on the one hand, and midwifery in the homes of the English people on the other. Methods and techniques which may be suitable for use in the former may be unpractical for use in the latter."

J. C. M. C.

STARR, S. H.: *The Present Status of Pain Relief during Labor.* J. Oklahoma M. A. 38: 7–10 (Jan.) 1945.

"Fortunately or unfortunately, the interest of the public along medical lines centers itself as often upon the problem of birth and its attendant management as upon any other medical condition. . . . Because of the tendency of the public to make strong pressure upon the physician to alleviate pain the so-called fashionable method, it is extremely important that we as physicians view this entire picture in perspective so that we may be the proper judges as to the most efficient method to relieve pain during labor.

"It is most important to decide first what the criteria are for a satisfactory method for conducting labor. Obviously the most important single factor is safety to mother and baby. . . .

"All the methods for relief of pain, besides the annoying complications of administration or excitability, carry a certain small percentage of danger to the baby if they are administered at the improper time, in too large dosages, or if the patient is not in the proper environment for control. . . .

"Caudal anesthesia is not new in obstetrics, but the idea of continuous caudal anesthesia is. . . . The obvious advantage of continuous caudal anesthesia when successful is a truly painless labor. . . . The disadvantages in regard to universal use of this method are that there is a high incidence of forceps deliveries due to the absence of the expulsive powers of the mother, this method is not applicable for home deliveries, and during the course of labor there must be constant attendance upon the patient. There are certain contraindications to this method such as deformities of the sacrum and injection into the spinal canal. In order to carry out the method successfully a thorough knowledge of the anatomy of the sacral regions is necessary and there must be considerable practice to carry out the technique of insertion of the needle. . . .

"My opinion, and what I have attempted to teach my students concerning the management of the patient in labor in regard to pain relief, is this: during the prenatal period, observe the patient constantly and carefully. Evaluate her fears and temperament. Win her confidence. Tell her frankly, if she inquires, that you will do all possible that you can to alleviate her discomfort as long as it is not dangerous to her or the baby. If that is achieved, well and good. I believe that there is much more advantage in this so-called psychotherapy and your ability to have the patient realize it than a great many people admit. . . .

"I have not discussed the inhalation anesthetics which are used for delivery. Because of the high oxygen content used with cyclopropane, I consider it most desirable, but the disadvantage of needing a trained anesthetist and expensive apparatus must be admitted. Ether is probably the most satisfactory anesthetic for universal use. Chloroform to a surgical degree carries too small a margin of safety, nitrous oxide and ethylene have the same

disadvantages as cyclopropane and are not as effective in my opinion.

"To supplement these methods also, local anesthesia is very popular with those who have used it to a great extent and in certain cases, where a general anesthetic is contraindicated, it may be given to supplement the various forms of drugs given hypodermically, by mouth or by rectum during the first stage of labor."

J. C. M. C.

MYLKS, G. W., JR.: *Report on the Use of Continuous Caudal Anaesthesia in Sixty-five Obstetrical Cases.* Canad. M. A. J. **52**: 169–173 (Feb.) 1945.

"The apparatus and technique used in these cases were those described by Hingson and Edwards. The drugs used were, procaine 1.0% solution in 11 cases, metycaine 1.5% solution in 42 cases, and pontocaine 0.25% in 9 cases. In 3 of the 65 cases the procedure was used for Caesarean section. Excellent results were obtained in 50 cases, fair results in 8 cases and poor results or complete failure in 7 cases." 9 references.

J. C. M. C.

FREE, EUGENE G.: *Five Hundred Consecutive Cesarean Section Operations.* Am. J. Obst. & Gynec. **49**: 401–408 (March) 1945.

ANESTHESIA

"Local alone—280 cases (58 per cent); local and cyclopropane—62 cases (12.4 per cent); local and ethylene—12 cases (2.4 per cent); local and ethylene and ether—3 cases (0.6 per cent); cyclopropane—110 cases (22 per cent); ethylene—8 cases (1.6 per cent); ethylene and ether—19 cases (3.8 per cent); ethylene and ether and cyclopropane—2 cases (0.4 per cent); cyclopropane and ether—2 cases (0.4 per cent); cyclopropane and ethylene—1 case (0.2 per cent); none—1 case (0.2 per cent).

"A solution of one-half per cent novocain in local infiltration held predominant position as an anesthetic agent. As complementary anesthesia, cyclopropane was favored over ethylene or ether. Cyclopropane alone was used in over one-fifth of the cases, the indications usually being an uncontrollable or nervous patient, or necessity for rapid operation."

A. W. F.

DOWNING, GEORGE C.; MILLER, MARCIA, AND DURFEE, R. B.: *The Catheter Method for Continuous Caudal Anesthesia.* Am. J. Obst. & Gynec. **49**: 391–395 (March) 1945.

"Indications.—Caudal anesthesia for obstetric patients is instituted only when labor has made definite progress. The primiparous cervix should be dilated at least 4 cm., while 2 to 3 cm. is sufficient in the multiparous patient. Uterine contractions in all instances should be at intervals of 3 minutes or less.

"Preliminary Preparation.—Premedication with a barbiturate—usually 3 grains of nembutal or seconal are given 15 minutes beforehand. The bladder is emptied, and the large bowel cleansed with a low enema.

"Technique.—The patient is placed face down with the hips elevated by a large pillow. The sacral region is painted with tincture of phemerol or merthiolate and draped with sterile towels. The sacral hiatus is identified and a wheal is raised in the overlying skin with local anesthetic solution. Metycaine, 1.5 per cent, has proved satisfactory. A 22 gauge 2-inch needle is connected to the syringe and passed through the skin wheal and the sacrococcygeal ligament into the caudal canal. When the caudal space is entered, a characteristic 'jump' is felt as the needle point traverses the depth of

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