

LENAHAN, N. E.: *Anesthesia in Thoracic Surgery*. Ohio State M. J. 41: 243-245 (Mar.) 1945.

"Anesthesia in thoracic surgery as practiced at University Hospital [Columbus, Ohio] is limited to cyclopropane, oxygen, helium, and ether. . . . The anesthetist . . . is concerned with the following problems: 1. To provide adequate oxygenation and relaxation. 2. To prevent a paroxysm of coughing. 3. To prevent paradoxical respiration. 4. To provide an open airway and the means to aspirate mucus and blood from the tracheal tree. 5. To carry out or supervise continuous circulatory resuscitation by means of fluids such as glucose, saline, plasma, or blood. 6. To maintain efficient respiration, under pressure if need be. . . . A thorough routine preoperative check-up is made on each patient. . . . The patient's status is decided upon as to operative risk and chance of success. Consultation with the anesthetic department as to the premedication and type of anesthesia is next in order. . . . In our hands cyclopropane-oxygen-helium-ether seems to be entirely satisfactory. . . . Occasionally one finds a patient who continues to cough, hack or hold his breath and in these cases we use sodium pentothal for an inducing agent, then cautiously add cyclopropane-ether until the proper depth of anesthesia has been reached for intubation. . . . By the use of the laryngoscope a woven catheter endotracheal tube with an inflatable cuff is then inserted into the trachea. . . . The depth of anesthesia after the skin incision is made, may be lightened and simply maintained below the cough reflex. . . . Novocaine is of value to infiltrate the periosteum of the ribs prior to stripping them. By so doing stimulation of respirations are not so pronounced, or, as occasionally happens, stop altogether for a few seconds. In pneumonectomies and lobectomies, no-

vocaine is injected into the hilus of the lung to block the vagus and its pulmonary plexus; the phrenic nerve also may be injected if necessary. With an open pneumothorax, positive pressure is very desirable. . . . During the operation positive pressure is usually maintained at 8-20 mm. pressure. . . . In analyzing our cases as to age groups, we found the greatest case age came in the 20-29 year olds. . . . The youngest operated on was 7 years old. The oldest was 67 years old." 1 reference.

J. C. M. C.

NICHOLSON, M. J.: *Anesthesia for Thyroid Surgery*. Surg. Clin. North America. Lahey Clinic Number 627-644 (June) 1945.

"General anesthesia is our choice for almost all thyroid operations because it fulfills the average patient's desire to be asleep and is relatively nontoxic. . . . Hypert thyroidism is a disease that affects the entire body, but the liver, gastrointestinal tract, cardiovascular and central nervous systems seem to be most vulnerable. Evidence of this vulnerability is found in the patient's complaints of nervousness, irritability, emotional instability, weight loss, weakness, fatigue, increased appetite, intolerance to heat, dyspnea, palpitation, vomiting and diarrhea. If postoperative reaction, crisis and death are to be prevented, an attempt must be made during the period of preoperative preparation to rectify these complaints. This can usually be done by bed rest, sedation, a diet high in carbohydrate, protein and vitamin content, plus iodine or thiouracil medication as indicated. . . . At this time it would seem that the use of thiouracil has more or less revolutionized the anesthetic management of the severely toxic thyroid patient. The indications for multiple stage operations have shown a striking de-