

of exhaustion, are all points of value.

"With the fairly general acceptance of the view that the cause of deterioration of the wounded patient's general condition is reduced circulating blood volume, problems of therapy become considerably simplified. This simplification is extended with the further acceptance of the evidence that, excepting the processes that lead to dehydration, fluid lost from the circulation is to be explained by loss at the injury site alone (except perhaps shortly before death, when some general increase in capillary permeability may occur as a result of profound anoxia). Therapy falls into three main channels: Treatment of the reduced blood volume; treatment of the local wound; and treatment of pain and mental distress. . . . Experience has shown that about 2.5 per cent of battle casualties (under the conditions of study) will require intensive resuscitative measures. . . . Surgery is an inseparable part of resuscitation in its broad sense. On occasion there can be no resuscitation, even temporarily, without surgery."

J. C. M. C.

FRUIN, R. L., AND McLAUGHLIN, C. W., JR.: *Adult Circumcision; Report of 854 Operations on Naval Recruits*. U. S. Nav. M. Bull. 45: 42-46 (July) 1945.

"Careful preoperative preparation was carried out, and [of 854 cases] local (1-percent procaine hydrochloride) anesthesia was used on 366 patients. . . . No patient was allowed to return to his station until the incision was completely healed. This averaged 14 days. Because it was thought that local infiltration with the procaine might be partially responsible for postoperative edema and tardy healing, spinal anesthesia, using 50 mg. of procaine, was employed instead of local. Two

hundred twenty-one consecutive patients . . . were operated upon this revised technic. . . . [In] 100 consecutive cases in our series local anesthesia (1-percent procaine to which from 10 to 12 drops of epinephrine hydrochloride per 30 cc. of solution were added) was employed. In no cases was more than 5 cc. of anesthetic solution utilized, in order to minimize distortion and trauma of tissue. In all cases satisfactory anesthesia was obtained. The operative technic employed in these 100 cases [was different than in other groups]. . . . The healing time in these 100 cases was 9.6 days."

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ROBERTS, F. W.: *Anaesthesia for General Practitioners*. Clin. J. 74: 64-68 (Mar.-Apr.) 1945.

"An obstructed airway is the most frequent cause of difficulty in anaesthesia, and if the airway is kept scrupulously clear, all other causes of anaesthetic dangers are the more easily counteracted. Obstruction to free breathing may occur anywhere between the lips or nostrils and the trachea. . . . If the head is turned to one side, then the action of gravity does not tend to approximate the soft tissues forming the anterior and posterior walls of the pharynx. . . . A soft rubber airway of suitable size and shape may be inserted in the mouth. . . . In some very awkwardly shaped faces neither a suitable position of the head nor a suitably shaped artificial airway can be found. A rubber tube introduced in one nostril reaching to below the base of the tongue, but above the epiglottis, may solve the problem. . . . Laryngeal spasm may occur if any spasm-producing stimulus is given while the patient is insufficiently anaesthetized. Such a stimulus may be either local to the larynx, or general. . . . Its prevention is the avoidance of any such stimulus under