

inadequate anaesthesia, and its treatment—when it does occur—is to stop the stimulus, keep the rest of the airway clear, give pure oxygen so that when the next breath is taken it will most quickly rectify the resultant anoxia, and then to deepen the anaesthesia sufficiently before allowing the stimulus to recur. Vomiting during anaesthesia is another source of obstruction. . . . Vomiting can be largely prevented by avoiding general anaesthesia on a full stomach. . . . When vomiting does occur the operation should be temporarily suspended, the pharynx and mouth and nose cleared of vomitus by swabbing or suction, or both. When the airway has been restored the anaesthesia is deepened to the requisite level before the operation is continued. . . .

“Nitrous oxide is generally assumed to be the safest of anaesthetics. Two points are not realized as fully as they should be: First, it is safe only if enough oxygen is given with it. Second, when enough oxygen is given with it, it is a poor anaesthetic agent. . . . Notwithstanding all the criticisms raised against it, by the protagonists of ultramodern anaesthesia, ether is probably the safest stand-by of the general practitioner anaesthetist. . . . Chloroform . . . should never be used to obtain profound muscular relaxation, nor for any prolonged operation. Ethyl chloride . . . should be used with the greatest care—only as an induction or for very short anaesthesia—and the strictest attention paid to the clear airway. . . . I do not think sufficient trial has been made of [trilene] . . . to recommend its use by the non-specialist anaesthetist. . . . Always try to find out what operation the surgeon is going to do, what position he will want the patient in, the depth and probable duration of the anaesthesia, and whether the diathermy or cautery is to be used. These simple data will

help you considerably in deciding what anaesthetic agent or agents to use, how to maintain a perfectly unobstructed airway, and whether you are likely to need prophylactic or resuscitative intravenous saline, blood or plasma. . . . The patient's general health must, of course, always be taken into account in deciding what anaesthetic to give. . . . There is no such thing as fool-proof anaesthesia, but fools should not attempt to give anaesthetics.” 1 reference.

J. C. M. C.

SIDDONS, A. H. M.: *Sympathetic Block in Vascular Injuries*. *Lancet* 2: 77 (July 21) 1945.

“In the last few years a number of papers have appeared recommending sympathetic nerve block by injections of local anesthesia for limbs in which arterial injuries have endangered the blood-supply. . . . In the absence of clinical proof of the value of sympathetic block in traumatic lesions of major vessels its physiological basis merits careful consideration. . . . Experimental work in human beings, in which the blood-flow to the skin and muscles of the limbs is measured with a plethysmograph or by skin and muscle temperature readings, has shown that while sympathetic paralysis causes vasodilatation in the superficial vessels it usually constricts the muscle vessels. . . . In wounded limbs with an endangered blood-supply, muscle ischaemia is usually more extensive than skin ischaemia, and sympathetic block is then contra-indicated. . . . In traumatic arterial spasm sympathetic block does not always relieve the condition and may do harm.” 19 references.

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KARP, MARY: *Anesthesia for the Urological Patient: a Review of 973 Cases*. *J. Urol.* 53: 740-748 (May) 1945.