

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.

J. C. M. C.

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

"The urological case has always presented an anesthesia problem. In a larger percentage than in other specialties, the patients are bad surgical risks. . . . The past year of urological surgery at Wesley Memorial Hospital was investigated and 973 cases were analyzed. Procedures accomplished under local or topical anesthesia, comprising an additional 300 cases, were not included in this series. . . . Intravenous anesthesia far surpassed all other methods. It was administered in 67.4 per cent of cases. Spinal anesthesia was used in 22.2 per cent, and the other anesthetics made up the remaining 12 per cent. Pentothal sodium has certainly become a popular agent in a short period of time. When used cautiously and with understanding, it has proved to be a boon to the urologist. . . . Intrathecal injection has been the method of choice in many of the urological cases. We prefer pontocaine 1 per cent in dextrose 10 per cent, and nupercaine $\frac{1}{4,500}$ as the anesthetic agents. . . . The procedures which are done in the decubitus position such as nephrectomy, ureterolithotomy, or the plastic operations on the kidney and ureter have been best performed under nupercaine-light anesthesia, using a 1:1500 dilution. . . . Novocaine in the crystalline or 10 per cent solution form, or metycaine 10 per cent is occasionally used in genitourinary procedures, but the time restriction for the surgeon has been its chief contraindication."

J. C. M. C.

O'CONNOR, H. A. D., AND BESSIE, E. M.: *Appendicitis: A Survey of the Last Two Thousand Consecutive Cases*. New York State J. Med. 45: 1535-1538 (July 15) 1945.

"By presenting a part of our experiences at the-Brooklyn Naval Hospital . . . we hope to give a picture of how this troublesome menace is man-

aged in this institution. . . . The entire series here presented is taken from the service of the senior author at this hospital, and constitutes a completely unselected series of 2,000 consecutive patients operated upon for appendicitis. . . . If operation is delayed a simple cleansing enema, $1\frac{1}{2}$ grains of phenobarbital by mouth as a sleeping medication, and $\frac{1}{4}$ grain of morphine sulfate and $\frac{1}{4,500}$ grain of atropine sulfate when the patient is called to the operating room, are routine orders. . . . We are strongly in favor of spinal anesthesia as the anesthetic of choice for these cases. Not one single case of the entire 2,000 was started on any other type of anesthesia. One thousand seven hundred and twenty-three were given 150 mg. of procaine crystals dissolved in 3 cc. of spinal fluid, and 184 were given 16 mg. of pontocaine 'snow' dissolved in 3 cc. of spinal fluid. All of these had more than satisfactory anesthesia. The remaining 93 were given procaine crystals intrathecally, but due either to poor administration, a prolonged procedure because of technical difficulties, or an occasional case in which a seemingly perfect tap was done, yet the patient was apparently refractory to spinal anesthesia, and required the reinforcement of gas-oxygen-ether by inhalation. . . . As experience has taught us that almost one in every four appendices is retrocecal and frequently extends high up toward the liver, we administer our spinal anesthetic agents at a relatively high level—usually between the first and second lumbar spinous processes, frequently an interspace higher, and always with the patient lying on his left side. Every patient has first approximately 2 cc. of 1 per cent novocaine injected through a fine needle, then, after dissolving the anesthetic agent in spinal fluid, it is reinjected into the thecal canal at the rate of 1 cc. per minute—a total of