"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 1/1500 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 managed 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, 1½ grains of phenobarbital by mouth as a sleeping medication, and ¼ grain of morphine sulfate and 1/150 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

three minutes being taken in each case. Three-quarters of a grain of ephedrine sulfate is administered on the operating table just prior to the spinal tap. Blood pressure readings are taken routinely throughout the operation, and we have but rarely experienced a drop in blood pressure sufficient to require the administration of a vasoconstrictor. Our incidence of postspinal headaches has been practically negligible. . . .

"In the entire series we had but one death, this resulting from an overwhelming general sepsis. . . . We had 13 cases of atelectasis proved by x-ray. Undoubtedly other cases occurred, but our method of fist percussion over a flattened palm laid against the suspiciously affected posterior chest wall until the patient coughs up mucus has unquestionably aborted this condition and rendered x-ray findings negative."

J. C. M. C.

Portable Resuscitator. Bull. U. S. Army Med. Dept. No. 87 (April) 1945.

"A new portable, bellows type resuscitator (Med. Dept. Item No. 3725800) has been adopted by the Army and is being issued for distribution to medical units attached to combat troops. The apparatus consists of an expansible, bellows type bag of about 1,500 cc. capacity, a face mask, an elbow adapter, a metal pharyngeal airway, intake valves, and a pressure limiting valve which prevents pressures in excess of 20 mm. of mercury being exerted during resuscitation. The entire assembly weighs less than two pounds and is packed in a case 6 by 6 inches. This resuscitator should meet all needs for artificial respiration in the field. It can be removed from the carrying case and put into operation in a few seconds' time. There are no adjustments to be made. All valves are automatic. . . .

"There is no rebreathing and no accumulation of carbon dioxide in the bellows. The valves are arranged so that gases from the lungs are expired directly into the outside air. The lungs deflate because of their elasticity and the elasticity of the intercostal muscles. A mixture of the gases from the lungs and the air or oxygen in the bag is impossible. Each stroke of the bellows supplies only fresh air or oxygen to the lungs."

A. W. F.

PICKRELL, K. L., AND RICHARDS, R. K.: *Pentothal-Metrazol Antagonism. A Method of Shortening the Recovery Period Following Pentothal Anesthesia. A Clinical and Experimental Study.* Ann. Surg. 121: 495–507 (April) 1945.

"Conclusions

"The administration of metrazol given intravenously markedly shortens the recovery phase following sodium pentothal anesthesia in man. In addition, it has relieved profound respiratory depression which has occurred in seven instances in the present study."

A. W. F.

KATZ, L. N.; WISE, W., AND JOCHIM, K.: *Factors Controlling the Coronary Circulation.* J. Lab. & Clin. Med. 30: 374–375 (April) 1945.

"In the intact circulation coronary flow depends primarily on two passive factors: (1) the cardiac output per minute and (2) the state of constriction of the extracoronary systemic blood vessels. Furthermore, changes in these two factors can modify coronary flow independently of obvious arterial blood pressure changes.

"These facts, of course, do not negate the value of powerful coronary vasodilator drugs to supplement such mechanical (and other possible humoral) regulators. However, in employing such drugs care should be