eries, a lower incidence of stillbirths, a lower maternal morbidity, diminished blood loss with delivery, less permanent damage to the birth canal, and a pleasant, happy, cooperative patient. In other words, we have not yet found the utopian type of obstetric analgesia, but we are convinced that continuous caudal analgesia is a distinct advance in this field and an excellent method to add to the armamentarium of every obstetrician."

J. C. M. C.

BAPTISTI, ARTHUR, JR.: *Five Years' Experience with Caudal Anesthesia in Private Obstetric Practice.* Am. J. Obst. & Gynec. **50**: 180–184 (Aug.) 1945.

"In July, 1944, in a published commentary, I called attention to the fact that the administration of an anesthetic agent into the caudal canal is never risk free. I indicated that the use of an indwelling needle or catheter in the caudal canal increases the possible complications, and, more particularly, I attempted to point out that caudal anesthesia has an inherent tendency to arrest the progress of normal labor. Thus, even though the risk of caudal anesthesia may be minimized to the point of negligibility, its administration before the terminal stage of labor constitutes unsound obstetrics. These conclusions were based on a reasonably broad experience with caudal anesthesia in a large obstetric clinic during the years 1938 and 1939. . . . This present report concerns my experience with single injection, terminal caudal anesthesia for delivery during the five years that I have been in private practice. Most of this practice is done in the Washington County Hospital, Hagerstown, Maryland, an institution of about 175-bed capacity, where there are no resident house officers and no service cases. A small part of the practice is done as consultations in several smaller hospitals in surrounding counties. Under such circumstances any procedure used in private obstetric practice must be not only safe but simple and free from complications. . . . In the first 145 cases in this series, 1 per cent novocain was used as the anesthetic agent, and in the last 173 cases 1.5 per cent metycaine was used. . . .

"The present report reveals my experience with terminal caudal anesthesia attempted in 320 cases. In two cases administration was abandoned because the caudal space could not be penetrated. In two other cases supplementary anesthesia was necessary. In the 316 cases remaining, the procedure was completely satisfactory with no maternal or fetal complications. This series does not represent my initial experience with caudal anesthesia. In my earlier experience the percentage of failures was significantly higher, indicating that the administration is technically difficult and that practice and experience are essential for satisfactory results. However, I know that any other obstetrician can attain the same gratifying results. The only requisites are that he have patience and that he be a trained obstetrician. The obstetrician can master the technique of caudal anesthesia in a comparatively short time, but the anesthetist cannot become an obstetrician in that same short time." 2 references.

J. C. M. C.

HANLEY, B. J., AND MALONE, C. M.: *Caudal Analgesia in Obstetrics with Special Reference to Repeated Single Blocks.* Am. J. Obst. & Gynec. **50**: 306–311 (Sept.) 1945.

"The patient is placed in the modified Sims' position. If we find it too difficult to give the caudal in this position, we change to the knee-chest position. Our skin preparation consists of a scrub with tincture of green soap,