SMITH, J. M.: *Post-operative Vomiting in Relation to Anaesthetic Time.* Brit. M. J. 2: 217 (Aug. 18) 1945.

"General anaesthesia is a temporary pathological state, but with the improvements in methods of administration of the last few decades there is a tendency for light general anaesthesia to be regarded as harmless. On the whole it may be true that no lasting harm accrues from prolonged anaesthesia, but it would appear, from observations made over a period of 18 months [in a series of 1,000 cases] on the incidence of post-operative vomiting, that the duration of anaesthesia is a definite factor in the amount of constitutional upset and post-operative discomfort in the patient. . . . The cases . . . were largely (90%) patients undergoing plastic surgical procedures, mostly in the head and neck regions and requiring endotracheal anaesthesia. . . . It might be argued that the increase in vomiting with increase in duration of anaesthesia is due to the production of slight degrees of anoxia by surgical shock. This may very well be true; but, generally speaking, plastic operative procedures rarely cause any demonstrable degree of shock unless associated with considerable haemorrhage. . . . Judged on the numbers [230 cases] available, the incidence of vomiting in children does not appear to be significantly altered by the duration of anaesthesia." 2 references.

J. C. M. C.

VALLE, ANIBAL ROBERTO: *Lung Abscess. An Analysis of 244 Cases.* Surg., Gynec. & Obst. 81: 278–286 (Sept.) 1945.

"Bronchoscopy. Most of our bronchoscopies are performed under avertin anesthesia administered rectally, 85 milligrams per kilogram of body weight. In poor risk patients or patients with severe heart conditions we use local anesthesia, pontocaine 2 per cent. . . .

"Surgical treatment. . . .

"We use general anesthesia in all cases but at times use avertin as an induction anesthesia. We use either nitrous oxide or intravenous pentothal.

"We consider the following as possible preventives of lung abscess following surgery: (a) good care of teeth, gums and throat before a contemplated operation; (b) avoidance of the use of strong sedatives before and after operation because they decrease the cough reflex; (c) frequent aspiration of the trachea and bronchial tree by nasal catheter; (d) the encouraging of the patient to cough after operation; (e) early aspiration bronchoscopy in a postoperative atelectasis."

A. W. F.

HOWES, W. E., AND SHAPIRO, A. L.: *The Treatment of Advanced and Inoperable Cancer. A Resume of Current Trends Based on a Review of the Literature and Analysis of Personal Case Experiences.* Surgery 18: 207–228 (Aug.) 1945.

"*Pharmacologic Therapy.*—Foremost in importance among the medications given in advanced cancer are the analgesics. A cardinal principle to be followed in their administration is the postponement of narcotic utilization until the decreased potency of other drugs counterweighs the disadvantages of potential addiction. At the outset salicylates and barbiturates are generally adequate, later to be supplemented by codeine, which rarely causes serious habituation. Small doses of morphine, pantopon, or dilaudid may prove effective for long periods in the majority of cases. Whenever possible, relief of intractable regional pain by alcohol nerve block or neurosurgery is preferred to the deleterious effects of constant dependence on large doses of narcotics. On