

creased the incidence of asphyxia when used beyond safe limits of potency. Nitrous oxide or ethylene used to safe limits and then supplemented by a more potent agent gave the most favorable results. Cyclopropane and other more potent inhalation agents increased the incidence in proportion to the degree of tissue saturation. Complications of pregnancy and labor, particularly those necessitating operative delivery, increase the incidence of fetal asphyxia. . . . Asphyxia neonatorum may be the result of the complications of pregnancy and labor. It frequently involves poor diagnosis and management of the existing conditions by the obstetrician. It often involves the misapplication of depressant drugs through the failure of the anesthetist and obstetrician to recognize the physiologic disturbances and changes involved in the progress of labor, thus acquiring the relief of pain at the expense of safety. The choice of an anesthetic agent is not as important as its proper administration and individualization to the existing obstetric conditions. It cannot be emphasized too strongly that only by close cooperation between the obstetrician and the anesthetist can the mother and child be safeguarded against the hazards of childbirth." 6 references.

J. C. M. C.

ALLEN, FREDERICK M.: *Intravenous Obstetrical Anesthesia; Preliminary Report*, Am. J. Surg. 70: 283-290 (Dec.) 1945.

Adapting a procedure used by Lundy and by the Canadians Gordon and McLachlin, the author has set out to demonstrate to his own satisfaction that procaine has a selective affinity for tissues which are inflamed or whose capillaries are otherwise abnormally permeable, when the drug is administered intravenously. In his series of cases, Allen has achieved two grades of analgesia. One is a mere numbing

of peripheral sensation which is considered adequate in the second stage when pain is not too severe. Concentrations of 0.8 per cent procaine given usually at about 0.5 to 3 cc. per minute were enough, and the guide to the upper limit of dosage was the absence of subjective symptoms of dizziness or confusion. Rapid flows of 5 to 12 cc. per minute were used for the severe pain of actual delivery and repair. At these rates, fogging of consciousness was the rule. There were a few minor convulsive manifestations with these rapid flows, easily stopped by decreasing the rate of flow sharply. Prevention of these motor phenomena with preliminary barbiturate medication is not conclusively proven.

W. A. C.

ADAMS, R. C.: *Principles of Intravenous Anesthesia with Pentothal Sodium*. S. Clin. North America. Mayo Clinic Number 788-791 (Aug.) 1945.

"Many of the questions which are asked relative to the use of pentothal sodium anesthesia reflect the fact that the broad principles of its use are still not thoroughly understood. . . . Intravenous anesthesia is linked closely to both the principles and practices which govern the administration of anesthetic agents in general. Most of the difficulties and fatalities associated with intravenous anesthesia have risen from failure to appreciate this fact. . . . In the first place, pentothal sodium is a barbiturate. Although it has the desirable characteristic of being ultrashort acting, due to its rapid destruction in the body, nevertheless it exhibits many of the characteristics common to derivatives of barbituric acid in general. . . . Induction of anesthesia should be slow. . . . It is almost impossible to estimate beforehand how much of the barbiturate will be required to produce the optimal level of anesthesia for a particular patient. Consequently there is