infection, but having seen the way the spinal drugs are prepared and the care
taken in sterilization both of the ampoules and of the drug itself, the like-
lihood of contamination with organisms is very small indeed. . . . There
is some evidence in favour of 'chemical meningitis,' but I would not overstate
this. . . . With proper technique spinal anaesthesia is safe and is the method
of choice for certain operations. The risk of infection is spinal analgesia, if
performed in suitable surroundings and with adequate precautionary tech-
nique, is negligible. But if there is any deviation from this, then infection can
occur, sometimes with disastrous consequences.” 15 references.

J. C. M. C.

HUNTER, A. R.: Spinal Anaesthesia;
Variations in Dosage Required.

'The last year I described a new volumetric technique of spinal anaesthesia
based on the use of the minimal effective subarachnoid concentration of an
anaesthetic. Further experience has shown that this technique is not the
same for all persons. However, the limits of the variation are not wide
equivalent to invalidate the method, since it is a simple matter to forecast what
dose of a drug will be required for
any particular patient. . . . It is neces-
sary to increase the dosage in youthful,
athletic, and robust subjects, because
much of the drug is lost by absorption
into the blood-stream in these people
before it can affect the nerve-roots in
the subarachnoid space. As with all
other techniques of spinal anaesthesia,
adequate premedication is essential. A
few apprehensive subjects require sup-
plementary pentothal hypnosis, which
is also given as a routine during major
abdominal operations. The technique
is applicable to spinal anaesthesia with
stovaine and monocaone. The incidence
of headache after spinal anaesthesia by
this method is independent of the drug
used.’ 2 references.

J. C. M. C.

OLDHAM, JOHN: Spinal Analgesia.
M. J. Australia 1: 432-435 (Mar. 30)
1946.

'This article has been written to
present the technique used and the
observations made in a series of 500
cases of spinal anaesthesia, and to offer
some suggestions resulting from this
experience. The cases occurred at an
Australian military hospital from Oc-
tober 1, 1944, to November 1, 1945.
The majority of subjects were in the
twenty to forty years age group, and
were mostly well-trained, healthy men.
The anaesthetic agent used was a hy-
perbaric solution of 'Nupereaine,' that
is, 1 in 200, or 'heavy solution.' . . .
There were approximately forty cases
of high spinal anaesthesia in the series,
including anaesthesia for cholecystec-
tomy, pyelolithotomy and nephrectomy.
This type of anaesthesia is much more
difficult to manage than low and mid-
spinal anaesthesia, and requires con-
stant full anaesthetic supervision at cer-
tain stages. . . . Low spinal anaesthesia
comprises analgesia for the sacral area.
. . . Mid-spinal analgesia is used for
lower abdominal operations and lower
limb operations, and also for operations
such as that for hydrocele, in which
tugging on the cord is necessary. . . .
High spinal analgesia is used for the
upper part of the abdomen—cholecs-
tomectomy et cetera; the cutaneous level
of analgesia usually rises as high as
the second dorsal vertebra . . .

'The for low spinal anaesthesia, punc-
ture is carried out with the patient in
a sitting posture in the 'attitude of
prayer,' the elbows on the knees and
the lower part of the spine well flexed.
The needle is introduced between the
third and fourth lumbar vertebrae, and
the patient is laid supine after one-
quarter of a minute to one minute. Op-