

of which is dependent on their structural relations to the mother compounds. It has been shown that this protective action is specifically directed against convulsions produced by procaine and that no inhibition of peripheral local anesthetic action of procaine occurs." 21 references.

J. C. M. C.

GOODWIN, J. F.: *Post-operative Pulmonary Atelectasis*. Brit. J. Anaesth. 20: 11-23 (Jan.) 1946.

"Collapse of the lung was first suggested by Gardiner in 1850, but was not recognized as a post-operative complication until about sixty years later. . . . In 1925 Lee and Jackson demonstrated bronchoscopically complete bronchial obstruction due to a tenacious plug of thick mucus. Atelectasis is probably the commonest pulmonary complication of abdominal operations. It is generally agreed that the two major precipitating causes are limited respiratory movements and bronchial obstruction with a mucous plug. . . . The analysis of cases carried out by D. S. King at the Massachusetts General Hospital in 1933, reveals the highest incidence of atelectasis in cases receiving local anaesthesia. The explanation of this lies probably in the fact that in these cases premedication is often pushed to the stages of basal narcosis, entailing larger doses of morphia and atropine derivatives. . . . All authorities maintain that the highest incidence of atelectasis occurs after upper abdominal operations. . . .

"The prevention of post-operative atelectasis has been the subject of many writings by anaesthetists, physicians, and surgeons, but agreement on general principles has been reached. Morphia may be given pre-operatively, but should be given only in small dosage post-operatively unless there is some very urgent indication for the

exhibition of large doses. If possible atropine should not be given as a pre-medication, and should never be given in the post-operative period because the patient appears to be "bubbly." After operation the patient should be encouraged to carry out simple breathing exercises designed to aerate the lung bases as fully as possible several times daily. Expectoration should be encouraged by the use of a simple potassium iodide mixture. The lower part of the chest should never be constricted by a tight binder. . . .

"Treatment of the established condition consists in efforts to remove the obstructing mucous plug, and to increase pulmonary ventilation. Measures designed to liquefy secretion and stimulate coughing should be instituted at once. . . . Percussion on the chest wall ("taping") over the collapsed lobe in order to dislodge the sticky plugs is also of value. Deep-breathing exercises are usually agreed to be useful, but the practice of giving frequent inhalations of 5 per cent CO₂ to promote hyperventilation is not universally approved. Those who do not advocate its use maintain that it tends merely to drive the mucous plugs further into the bronchial tree—possibly converting a localized lobal collapse into a diffuse lobular one. . . . G. Marshall and Foster Carter consider the most useful treatment to be the employment of Santé's manoeuvre, but they emphasize that it must be carried out without delay. The manoeuvre consists of placing the patient on his back and rolling him gently a dozen times, first on one side and then on the other. If this does not cause the plug to be dislodged and expectorated the procedure should be repeated four-hourly until the mucus is expelled. . . .

"Nearly all physicians are agreed that removal of the obstructing plug of mucus by endoscopic means has a place in the treatment of post-operative

atelectasis, but there appears to be little agreement at the present as to the optimum time at which to perform the operation, or how frequently the measure should be employed at all; since without doubt a large proportion of cases recover without any such interference. . . . The use of sulphonamides appears rational and necessary, and all patients should receive a full course as soon as the condition is diagnosed. . . . The drug of choice is sulphamezathine, and 6 g. daily should be given over a period of from five to eight days. Cyanosis or moderate respiratory distress should be the indication for oxygen therapy, preferably through a B.L.B. mask.

"The prognosis in the majority of cases is good, and the collapsed lobe usually expands fully within one or two weeks of efficient treatment being instituted. . . . While the lung remains wholly or partially collapsed the patient is running a risk of immediate pneumonia, late lung abscess, and remote bronchiectasis. . . . There is no doubt that while the optimum time for bronchoscopy is within the first twenty-four hours after collapse has occurred the procedure can be employed with benefit up to fourteen days after, and possibly longer. In fact, should simple measures fail to achieve any results within five to seven days, bronchoscopy should not be neglected." 10 references.

J. C. M. C.

ELAM, JOHN: *The Dangers of Modern Anaesthesia Demand the Improved Status and Remuneration of the Anaesthetist*. Brit. J. Anaesth. 20: 1-10 (Jan.) 1946.

"It was some little time after Simpson's first use of chloroform that doubts arose in the minds of some observers as to whether chloroform was a drug sufficiently safe for general use. For many years furious arguments

continued between those in favour and those against the use of this anaesthetic agent. Yet in all these arguments the real point was missed. It was not the agent in use which was of primary importance, but the anaesthetist in charge of the administration who was really the deciding factor. . . . There are modern drugs in daily use which might with good reason be considered far more dangerous than chloroform, and yet because of the ease with which they are administered their popularity increases. . . . The barbiturate group of drugs forms a very good example of these 'pleasant anaesthetics.' . . . For some little time the barbiturate group of drugs commonly used for intravenous anaesthesia were thought to be safe, but the ever-increasing mortality and morbidity associated with their administration is giving rise to some concern. . . .

"It is not so much a question of how to use these drugs but when to use them, for what type of operation, or what type of patient, and by whom they should be used. It is here that judgment is required. . . . Intravenous anaesthesia requires for its successful practice specially trained and experienced anaesthetists, a sufficient number of whom are not available. Unless the public are prepared to improve the status and reward of the anaesthetist, these specially trained experts will not become available and many lives will be lost as a result of foolish attempts to obtain 'medicine on the cheap.'" 22 references.

J. C. M. C.

CROUCH, D. M. E., AND MERRY, EDITH S. M.: *Epidural Analgesia for Caesarean Section*. Brit. J. Anaesth. 20: 24-34 (Jan.) 1946.

"The choice of anaesthesia for Caesarean section is of major importance and has always been a difficult problem. First, it must be safe for