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 sulphamethazine, 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.


"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.


"The choice of anaesthesia for Caesarean section is of major importance and has always been a difficult problem. First, it must be safe for
mother and child and, secondly, provide operative comfort for the surgeon. . . . Local analgesia by abdominal field block for such cases has not been altogether effective. . . . We have carried out a very modest series [using epidural anaesthesia] and do not advocate that it is necessarily anaesthetic of choice for all cases, but it does seem to be an answer for the type of case described where general anaesthesia is contra-indicated. . . . Premedication has been two doses of 100 mg.: of Pethidine, one 11/2 hours before and the second 3/4 hour before operation, given intramuscularly. . . . We have always explained the procedure simply to the mother, making clear to her the difference between touch and pain. . . . We use 1 in 600 Nupercaine in 0.45 Normal Saline, 45 c.c.m. in all, 10 c.c.m. of which is injected slowly, aspirating several times during its introduction. . . . Following this safety pause, a further 35 c.c.m. of Nupercaine are injected slowly, always aspirating several times and asking the patient to move her toes. This is well within the maximum dose and we have seen no toxic effects. . . .

"It is important to ensure that the patient is comfortable and those with the right temperament are engaged in conversation and others left to sleep. Those who definitely asked to go to sleep were given a light gas and oxygen supplementary anaesthesia or analgesia. Blood-pressure records were kept without much disturbance to the patient as they were fully acquainted with the sphygmomanometer and cuff during pregnancy. Several patients required no ephedrine at all and others who did responded to it very readily. Relaxation of the abdomen muscles was good, intraperitoneal packs were inserted without discomfort, exposure of the lower segment was painless and the abdomen was quiet. The babies have breathed spontaneously on delivery and no change in the foetal heart-rate has been observed following the injection. . . . Retraction of the uterus has been satisfactory in all cases and there has been no post-partum haemorrhage. An added attraction of the method is the prolonged period of post-operative freedom from pain and restlessness. . . . Certain contra-indications to its use must be mentioned. Sepsis at the site of injection. The absence of a negative pressure. An uno-operative patient." 4 references.

J. C. M. C.


"Regional anesthesia produced by blocking the pudendal nerves is not new, unusual, or necessarily difficult. . . . Some years ago we chose this form of anesthesia if incipient or demonstrable respiratory infection complicated labor. With increasing experience we have found it so satisfactory that it has become a routine procedure with the authors in all deliveries free from difficult instrumentation or manipulation, including breech extraction and instrumental rotation of the fetal head. Its importance in the birth of premature infants is apparent. . . .

"The method preferred is instituted after the cervix is fully dilated and the end of the second stage is imminent. . . . The addition of very light nitrous-oxide-oxygen analgesia affords great psychologic relief whether the second stage is ended spontaneously or by instruments. . . . In a large series of cases in which this form of anesthesia has been used, there has never been an untoward reaction or complication attributable to the anesthetic, nor has there been any instance of infection or induration of the ischiorectal.