

sult of displacement of the bony supports. In addition a low grade inflammatory reaction may be superimposed. The structures which appear to be responsible for pain in most of these cases are the tendons of the gluteus minimus, gluteus medius, and perhaps, the pyriformis. . . . Only those patients exhibiting tenderness above and behind the trochanter should be infiltrated. . . . With the tender points marked, a 3 inch No. 22 gauge needle is inserted through a skin wheal, and 5 cc. of 1 or 2 per cent procaine hydrochloride is deposited at a depth which varies from 1 to 2½ inches. Pressure or needling at the time of infiltration may cause the typical reflex radiation of which the patient complains. If no tenderness is present as compared to the opposite of unaffected side, injection is usually of no benefit. The injection may be repeated every fifth day.”

J. C. M. C.

ULLERY, J. C.: *Continuous Spinal Analgesia in Cesarean Sections: Its Advantages, Technique, and an Analysis of Three Hundred Cases*. Am. J. Obst. & Gynec. 52: 100-105 (July) 1946.

“The safety of continuous spinal analgesia lies mainly in the administration of smaller initial doses instead of the previous one-injection method. . . . The controllability of continuous spinal analgesia is of paramount importance in cesarean section. A very small dose of the drug is given to reach the desired level just above the operative field. Usually this will suffice for the operation. . . . In December, 1941, we gave our first continuous spinal analgesia for cesarean section at the Philadelphia Lying-In Hospital. Since that time we have used it in three hundred cases there and at the Philadelphia General Hospital and Delaware County Hospital. At first our cases were carefully selected. But as time passed and its safety was well demon-

strated, its administration has become almost routine for cesarean section. . . . There were no maternal deaths. There were sixteen fetal deaths but none which could be attributed to the anesthesia. . . . There were nine failures in which the operation could not be performed under continuous spinal analgesia completely. Five of these were due to technical failure to introduce the needle into the subarachnoid space, and in four cases it was necessary to use a supplementary anesthetic as the level was not sufficiently high to proceed with the operation. . . . Postoperative complications were no greater than with the inhalation anesthetics. Headache occurred in 5 per cent of the cases, urinary retention in 8 per cent. There were no motor or sensory disturbances. One pulmonary complication occurred; this was an atelectasis which required intermittent inhalation of oxygen plus postural treatment. Nausea and vomiting were considerably reduced over the inhalation anesthetics, as was postoperative distention. . . . Postoperative morbidity occurred in fifty-five patients (18.3 per cent). The standard classification of morbidity being used, i.e., and elevation of 102.2 F. or over on two successive occasions excluding the day of operation. . . . All of the babies (excepting the stillborn) showed no anoxemia, cried at once, were a good color, and required no resuscitation. . . . The technique is easy and requires only the care and caution that should be given when administering any anesthetic.” 4 references.

J. C. M. C.

GRANT-WHYTE, H.; BUSSCHAU, H. M.; JONES, C. S., AND PARK-ROSS, M.: *Annual Report from the Department of Anaesthesia, Addington Hospital, Durban, 1945*. South African M. J. 20: 331-335 (June 22) 1946.

“This report covers the period from 1st January, 1945 to 31st December,