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 needle 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.


“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 demonstrated, 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.


“This report covers the period from 1st January, 1945 to 31st December,
1945. . . . The department of anaesthesia in this hospital has been reorganized since 1944, and consists at present of an honorary visiting specialist, a senior anaesthetist on the Specialist register, and two resident anaesthetists of several years' qualification but without previous special experience. . . . During the twelve months under review the members of the department have administered 5,789 anaesthetics to 5,500 patients. . . . Ether by the open-drop method is our stand-by in all hours of need. . . . Nitrous oxide is also in wide use, both in surgery and in childbirth. . . . Ethyl chloride is used fairly frequently, especially in children. . . . Chloroform is seldom used, and only when very definite indications exist. . . . Cyclopropane has been used 13 times. . . . We have been very satisfied with cyclopropane, and hope to put it to wider use as the proper flow-meters and soda-lime become available. We have been unable to get an adequate supply of trilene (trichlorethylene), so have not been able to put this agent to any extensive trial. . . . Those patients receiving ether by the open-drop method were induced for the most part with ethyl chloride. . . . Pentothal sodium has been exclusively used for intravenous anaesthesia in this department, and has been employed in a wide and extending range of surgical procedures. . . . A hypobaric solution of 1:1,500 strength of nupercaine is used exclusively in securing spinal anaesthesia of whatever extent. We have abandoned the use of the term 'spinal' for this method of anaesthesia owing to its suggestive nature, and instead use a variety of names, including 'lumbar,' 'intrathecal block' or 'subarachnoid block.' . . . Of the 286 patient who received this form of anaesthesia during the year, one died while under its influence (an incidence of 0.35 per cent). . . . [Local anaesthesia includes] . . . all the methods of use of cocaine and the synthetic cocaine substitutes, apart from intrathecal use. . . . We use procaine and nupercaine (percaine) in varying strengths according to the desired results. . . . Local anaesthesia is used extensively in the casualty departments of the hospital for minor surgery, and . . . it has been used for half the surgical proceedings during the year.” 2 references.

J. C. M. C.


"Spinal anesthesia is perhaps the safest and best method of anesthesia in surgery below the diaphragm, especially that which requires considerable relaxation, provided the following requirements are fulfilled: (1) The surgeon or anesthesiologist giving the anesthetic must be well informed regarding the fundamentals and principles of spinal anesthesia. . . . (2) The patient must be a good surgical risk. (3) Deep breathing and leg exercises, as well as frequent change of position should be instituted as soon as the patient returns from the operating room. Spinal anesthesia is not necessarily the best method of anesthesia for poor risk cases; neither is it suited for the aged nor the very young. . . . This discussion of spinal anesthesia will be limited to anesthetics: (1) Procaine, and (2) Pontocaine-Glucose. The techniques employed are (a) single dose spinal, and (b) continuous, intermittent, or multiple dose spinal. . . . Too high anesthesia, with its resultant respiratory paralysis and hypotension, is a most serious complication but should be avoided by careful attention to details. Spinal anesthesia should not be used for minor surgical procedures. Respiratory complications are less after spinal anesthesia, provided deep breathing exercises and frequent change of position