tients with organic heart disease who present signs and symptoms of myocardial failure. A surgical emergency will allow no delay and the risk of immediate operation must be accepted. It is best to administer ouabain or a suitable digitalis preparation by intravenous injection in those patients who have not been receiving digitalis and who have congestive failure. Rapid digitalization can be accomplished by oral administration of digitalis or digitoxin if the operation in patients who have mild or moderately severe congestive failures can be delayed for a few days. The ventricular rate, if auricular fibrillation is present, furnishes a helpful guide to the effect of digitalization. Treatment is continued until the rate is about 70 beats per minute. Strict limitation of the sodium chloride content of the diet should be made in the patients who have pulmonary congestion and peripheral edema. Mercurial diuretics may also be advisable.

Postoperative complications such as pulmonary embolism, atelectasis and abdominal distention are not well borne by the patients who have congestive failure regardless of the adequacy of the preoperative treatment. Digitalis should be administered to patients who do not have congestive failure but who have had dyspnea on moderate exertion or who have enlargement of the heart, evidence of valvular disease, auricular fibrillation, auricular flutter, frequent premature beats or electrocardiographic evidence of ventricular strain or coronary artery disease, as well as to patients who have enlargement of the heart due to hypertension. In elderly patients who do not have a diminished myocardial reserve, there is no evidence that preoperative use of digitalis is of any benefit. In the presence of serious heart disease the simplest operation which will accomplish the desired result is the procedure of choice. Certain heart conditions, even under normal conditions, are liable to result in sudden death of the patient. Recent myocardial infarction, angina pectoris, aortic stenosis, syphilitic aortic insufficiency and complete auriculoventricular block complicated by the Adams-Stokes syndrome should be detected before operation. Even mild anoxia or shock during anesthesia may cause sudden death. In the presence of these conditions it may be desirable to proceed as far as possible with local anesthesia. Spinal anesthesia causes a decrease in blood pressure and coronary flow. Reduced coronary flow may initiate a fatal arrhythmia or acute myocardial infarction. A skillfully administered anesthetic does not increase the work of the heart to an important degree.

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BAURYS, WILLIAM: *Cystoscopic Technique and Instruments—General Considerations.* Urol. & Cutan. Rev. **50**: 610–613 (Oct.) 1946.

Older instruments and technics made cystoscopic examination painful. By the use of newer instruments and perfection of technics cystoscopy should be accepted by the patient as a routine examination. General, caudal or spinal anesthesia leaves the patient with the impression that he is submitting to a major procedure. Intravenous anesthesia with pentothal is safe and pleasant when it is administered by a trained anesthetist. Local anesthesia using 2 per cent intracaine is used in the male urethra. In the female, under ordinary circumstances, no local anesthesia is necessary. Lubricants in which the anesthetic is incorporated may interfere with proper visualization. Instillation of one ounce of a solution of nupercaine in oil will aid in relieving the distress of an extremely irritable bladder.

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