

relaxation, in cases with general toxemia and in certain exigencies of practice, such as a single-handed emergency. Mental instability, organic central nervous system diseases, septic condition in the lumbar area, pyema, some deformities of the spine, myocardial deficiency, profound anemia, low blood pressure and dehydration are contraindications to the use of spinal anesthesia. Sound judgment is only obtained by clinical experience with spinal anesthesia.

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CLARKE, I. T.: "*Gas, Oxygen, and Ether*." M. Press **216**: 466-467 (Dec. 18) 1946.

Literally the term "gas and oxygen" anesthesia means anesthesia produced by gas and oxygen only. This combination has a limited field of usefulness. It may be suitable for cases where muscular relaxation is not necessary. It has a wide field in minor surgery, the dressing of painful wounds, and in dental surgery. Often the term "gas and oxygen" is used improperly to describe a variety of anesthetics in which these agents are only part of the mixture or a vehicle for more potent agents. Heavy and cumbersome apparatus limits the usefulness of gas and oxygen anesthesia. The occasional anesthetist should be aware of the limitations of gas-oxygen anesthesia and of the asphyxial element which may be present as well as marked myocardial weakness or impending heart failure which may be present in some cases. There is evidence that a new era is beginning when deep general anesthesia will be unnecessary. Light anesthesia with some adjuvant, like d-tubocurarine chloride, will be used instead of profound inhalation anesthesia.

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SMALL, ALAN: *Anaesthesia in Gastric Surgery: A Surgeon's Point of View*. M. Press **216**: 464-465 (Dec. 18) 1946.

Pulmonary complications are among the greatest causes of mortality and morbidity following major gastric operations in the adult. The gastric surgeon demands an anesthetic which is safe and which allows him to perform an adequate and extensive operation. In addition he would like an anesthetic which is completely reliable in its effects and which reduces to a minimum the post-anesthetic complications. Most anesthetics in popular use today fall short of perfection. The anesthetic which most nearly approaches the ideal is curare with an inhalational agent. Intubation should be performed as a preliminary to the administration of curare. The anesthetist must be prepared for flexibility in dosage, he must be able to administer a non-irritating inhalation anesthetic, and be prepared for controlled respiration at any time. The smallest possible premedication should be given. The anesthetic of choice for operations for congenital pyloric stenosis is a local anesthetic administered by the surgeon. 1 reference.

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PLEASANCE, R. E.: *Intravenous Anaesthesia*. M. Press **216**: 467-469 (Dec. 18) 1946.

In 1872 Ore, of Lyons, France, gave the first successful intravenous anesthesia in man, using chloral hydrate. Subsequently a large number of drugs have been introduced and tested. Veronal, the first barbiturate to be synthesised, was introduced by Fischer and von Maring in 1903. The first barbiturate to be used intravenously was somnifaine, introduced by Fredet and Perlis in 1924. Pernoston was introduced in 1927, by Bumm; avertin in 1929, by Kirschner; sodium amyral