Cases of traumatic shock were placed in one of four etiologic categories: (1) trauma and hemorrhage; (2) trauma and hemorrhage plus contamination or sepsis; (3) trauma hemorrhage plus cardiorespiratory embarrassment; (4) trauma and hemorrhage plus contamination or sepsis plus cardiorespiratory embarrassment. Treatment was directed to deal with all these etiologic factors.

If, on admission, a soldier's blood pressure was unobtainable, 500 cc. of low titer group O blood was given in five to ten minutes; if the blood pressure did not respond, the transfusion was repeated. When a systolic blood pressure of 70 mm. of mercury was obtained the rate of transfusion was decreased. All blood after the first 1,000 cc. was cross matched, and in cases of less severe shock all blood was cross matched. Oxygen was given. Should the blood pressure have failed to respond to whole blood, surgical intervention was considered and the transfusion continued as the patient was moved to the operating table.

Further replacement therapy was dictated by findings at operation. Peritonitis and peritoneal contamination without much blood in the cavity was an indication for plasma rather than for more blood. After the systolic blood pressure approximated normal, 1,000 cc. more blood or plasma was given.

Casualties with numerous or extensive wounds were considered in impending shock even with a relatively normal blood pressure and were given 1,000 cc. of blood before operation or radiologic examination.

In the postoperative period anemia was the rule; normal hematocrit readings were sought early by means of further blood transfusions.

The blood furnished to forward hospitals was all group O but titered for anti A and anti B agglutinins. When the agglutinins were in a titer greater than 1 to 64 the blood was reserved for group O recipients only. When the agglutinins were present in a titer less than 1 to 64 the blood was considered low titer group O and could be given to group A, group B, and group AB recipients and to any emergency case without cross matching up to 1,000 cc. Blood was drawn from donors, excluding those with a history of jaundice, malaria, or syphilis, into vacuum bottles containing citrate, and topped with dextrose solution. It was checked for syphilis and malaria. Refrigeration was maintained continuously until use, which was not more than seven days later.

Whole blood was essential in the management of casualties at the time of reparative surgical intervention in base hospitals. Daily transfusions up to 1,000 cc. until hematocrit readings were normal permitted successful early reparative operations of great extent.

Snyder concluded that the loss of whole blood rather than of plasma is the cause of reduced blood volume in cases of traumatic shock; that rapid replacement of whole blood, properly coordinated with other resuscitative measures (including surgical intervention) is essential in the treatment of severe shock; that adequate replacement of blood shortens convalescence and reduces morbidity; that cases of infected or complicated wounds should receive repeated transfusions to maintain a normal hematocrit; that low titer group O blood should be available for emergencies in civilian practice. 11 references.

R. R. C.


The Anesthetic Department of the Georgia Baptist Hospital, Atlanta,
tried using curare with pentothal-oxygen in abdominal surgery and the results were so gratifying that this practice is now surpassing the other forms of anesthesia used. The authors compiled the pertinent facts of 609 major operations in which this method was used. For comparison, statistics were also compiled on a corresponding group of cases on which pentothal alone was used.

The drugs were administered by three-way stopcocks, and oxygen was given continuously. The addition of curare diminished the amount of pentothal used by 19.3 per cent and was undoubtedly the big factor in reducing the length of postoperative sleeping. In a few cases there was a drop in blood pressure. Artificial respiration was not indicated in a single instance. Phlebitis did not occur in any case.

The authors prefer the synergistic effects of pentothal-oxygen-curare in abdominal surgery for the induction is rapid, the effects pleasant for the patient, postoperative complications are lowered, and the danger of explosion minimized.

M. F. P.


Criticism of hospital management of anesthesia service is rapidly growing. This is a serious matter of medical ethics since anesthesiology is a recognized medical specialty and not merely a technical service to be bought and sold at a profit. A resolution of the Board of Trustees which has been accepted by the American Hospital Association states: "A qualified medical specialist in anesthesiology is entitled to recognition as a professional member of the medical staff and as head of a hospital department... Neither the hospital nor the anesthesiologist should exploit the patient or each other."

If the hospital collects in anesthesia fees more than is spent to provide anesthesia services, the patients are being exploited. The niggardly salaries paid to many anesthesiologists represent exploitation of the physician anesthetist. Anesthesiology is part of medical practice. Only a physician trained in physiology and pharmacology of the anesthetic process correctly manages the minute details. Surgeons are not technically nor scientifically prepared to supervise anesthesia administration. Nurses are outdistanced by the new and necessary anesthesia procedures. Other services of the anesthesia department include preoperative medication,