developed respiratory infection within the first week after operation, 15.9 per cent succumbed. No good-risk patient developed respiratory infection.

Thirty-nine patients developed nervous sequelae. Transient diplopia was noted in 3 cases. In 1.7 per cent of the patients retention of urine occurred. No major nervous sequelae developed in this group of patients.

The authors regard sacral and lumbar block as relatively safe, even when performed on handicapped patients. They consider thoracic block to be in a different category. Disturbances of the autonomic and respiratory mechanisms become greater with increasing cranial extension of analgesia. Technical simplicity may lend to misuse of spinal analgesia. When the method is chosen unwisely, the results may lead to calamity, especially for the seriously ill patient. The choice, not the method, is to be blamed.

F. A. M.


In a series of 421 cases seen by a plastic maxillofacial surgical team, there were 9 in which general anesthesia was used. Local anesthesia was more difficult and more trying to the operator, but it was considered better to carry out the long procedures without adding the risk of general anesthesia. Premedication consisted of morphine sulfate, $\frac{1}{4}$ grain, atropine sulfate, $\frac{1}{150}$ grain, and seconal or nembutal, $\frac{1}{2}$ grain. Blocking of the second and third divisions of the trigeminal nerve was frequently used. Cervical cutaneous nerve block, infiltration and topical anesthesia were employed. Peripheral blocks were used to re-enforce deep blocks.

Two per cent procaine hydrochloïde with 3 to 5 drops of 1:1000 epinephrine to the ounce was used for all nerve blocks. Procaine hydrochloride, 0.5 or 1 per cent, was used for infiltration, either with or without epinephrine. Topical anesthesia was produced by application of 2 per cent tetracline hydrochloride or 5 to 10 per cent cocaine hydrochloride. Many methods and approaches should be learned for this type of anesthesia because, in traumatic surgery, some of the landmarks may be destroyed. The anesthesia following block of the gasserian ganglion was patchy and it was found that a combination of deep and peripheral blocks was superior.

The work was done in evacuation hospitals and covered the period which included the battles of Normandy, France, the Ardennes, the Rhineland and Central Germany.

F. A. M.


The skin temperature during operation is recorded by a small mercury-in-glass thermometer which is without constriction and reads from 80 F. to 107 F. The bulb is in the form of a ring, one side of which touches the skin of the forehead to which it is fastened by a strip of elastoplast. The temperature of the face of the average anaesthetized patient is between 92 F. and 95 F.

When the thermometer is first applied, there is a slow rise. A fall of 1 F., after this initial rise, is of slight significance, but a fall of 3 F. or more denotes a considerable degree of shock. Changes of skin temperature are independent of changes of blood pressure. A low blood pressure without a falling skin temperature may be of little significance. A constant blood pressure with a falling skin tempera-
ulcers due to various causes were treated with the ointment. Healing was rapid, no infection was observed during treatment and scars were soft and supple. No irritation occurred. Of the patients treated and the persons receiving patch tests, none showed sensitivity to benzocaine. 9 references.

F. A. M.


The recent introduction of preparations of curare of greater purity than formerly and of standard potency has revived interest in the drug. Intocostrin, one of the preparations of curare, is used as an adjunct to general anesthesia. It is also used to soften the convulsive phase in the metrazol treatment of psychoses. Scattered reports have appeared regarding its use in the treatment of some diseases of the neuromuscular system. The idea of using curare in the treatment of tetanus was reported as early as 1860.

Death from overdosage of curare has generally been ascribed to asphyxia from paralysis of the respiratory muscles. This premise is not strictly correct as death has been known to occur from circulatory failure. In the treatment of tetanus, curare should be limited to overcoming the muscle spasm. The cause of the disease should be treated by other means.

Five patients in whom the diagnosis of tetanus was established were treated with curare. Undiluted, aqueous solution of curare (intocostrin) containing 20 units of standard curare per cubic centimeter was used in all cases. Equipment for artificial respiration and for administering oxygen was available at all times. The recommended dose of one-half unit per pound of body weight was computed for each

F. A. M.


There are certain prerequisites which physiologists agree are essential for normal repair of injured tissues. These are: (1) adequate amounts of ascorbic acid, (2) equilibrium of serum proteins and (3) normal carbohydrate metabolism. In recent years there have been indications that local anesthesia may play a significant part, especially when pain is a factor.

An ointment was used which contained less than 1 per cent of paraaminobenzoate, with a small amount of cod liver oil for its analgesic and healing properties. Sodium propionate was added to increase the antisepsic properties of the ointment. Burns and hypostatic ulcers were selected to determine the effect of a local anesthetic on tissue regeneration. Sixty subjects were tested by 240 patch tests for primary irritation and hyperallergization. Only one patient reacted positively to the ointment. Tests with various ingredients showed that this patient was sensitive to benzyl benzoate.

The ointment was used on sixty-six patients who had burns of varying degrees. Thirty-one patients who had...