

on initial diameter of capillary endothelium, (6) the dose given."

J. C. M. C.

WRONG, H. A.: *The Modern Trend in Anesthesia in Urological Surgery*. Urol. & Cut. Rev. 52: 656-658 (Nov.) 1948.

"Local anesthesia has a very limited value in urological surgery. . . . Pentothal sodium . . . is definitely a drug which has proved highly successful in many minor urological conditions and also in some major procedures. . . . Cyclopropane, also of the more modern anesthetics, must still be considered an ideal inhalation anesthetic agent. . . . Spinal anesthesia cannot be considered a modern anesthetic in the true sense of the word, but we must give it a modern place for it is still an anesthetic of choice in any genitourinary operation. . . . Preoperative sedation is important in spinal anesthesia. . . . One of the greatest modern additions to the armamentarium of the anesthetist is curare. This product is in no sense an anesthetic agent but a drug which in a supplemental capacity does help very materially in that so necessary relaxation needed in upper abdominal urological surgery."

J. C. M. C.

GRIFFITHS, H. W., AND GILLIES, JOHN: *Thoraco-lumbar Splanchnicectomy and Sympathectomy*. Anaesthesia 3: 134-146 (Oct.) 1948.

"The operation of thoraco-lumbar splanchnicectomy and sympathectomy provides several interesting problems in anaesthesia. 1. The patients suffer from essential hypertension. . . . 2. For good exposure a long oblique incision is made from the lateral margin of the erector spinae to the lateral margin of the rectus abdominis. . . . For this approach the patient must be in the right or left lateral position with acute flexion to widen the ilio-

costal interval. 3. The surgical technique demands an ischaemic field. . . .

4. The use of diathermy inside the thorax does not permit the use of inflammable agents. 5. Dissection of the parietal pleura may produce an open pneumothorax. . . . 6. Finally, these subjects should be fit for a similar operation on the other side, preferably within 14 days. . . .

"Total spinal block has been employed combined with light general narcosis and efficient oxygenation in cases where by such means certain surgical requirements could be adequately satisfied. The operation of thoraco-lumbar splanchnicectomy and sympathectomy is one in which this technique would appear to be appropriate but it must be emphasized that such a method is safe only when circumstances permit the patient to be kept in the Trendelenburg position. . . . Assessment of the condition of the patient under total spinal block is difficult. The usual guides such as the radial pulse rate and brachial blood pressure are frequently not obtainable and respiration may be under passive control. Therefore one must depend on the patient's colour and the filling time of his capillaries. . . . Our belief that hypotension due to high spinal block is innocuous as long as there is no serious interference with capillary circulation and cellular metabolism, can only be considered proved after a careful assessment of the functional activities of certain organs which might be damaged during a period of hypotension, i.e. the kidneys, the brain and the heart. . . . The reduction in operating time and the complete insignificance of any loss of blood are advantages which contribute to the undoubted value of the method and the satisfactory results achieved. Frequently, the hypotension induced has been extreme, possibly unnecessarily so. As the series proceeded equally satisfactory results have been obtained

with systolic pressures of about 70 mm. Hg, which may be regarded as the optimal level." J. C. M. C.

GALLEY, A. H., AND KING, A. C.: *Modifications of the Clover's Ether Inhaler*. *Anaesthesia* 3: 147-153 (Oct.) 1948.

"In the interests of historical accuracy we should render 'honour where honour is due.' We must pay homage to John Snow whose practical mind, so early in the history of anaesthetics, appreciated the fact that airways in ether inhalers should be ample and adequate in calibre. Dr. T. Wilson-Smith re-introduced this wide-bore principle (so long forgotten, like so much of Snow's sound observation and advice) when modifying Clover's inhaler. Hewitt's fame as an experimenter and clinical anaesthetist probably placed the 'hallmark' on the principle when he modified this inhaler, independently, some two years later. Both men recognized that the narrowness of the internal calibre of Clover's inhaler caused an unnecessary restriction to respiration and that increased airways gave markedly improved clinical results. Nobody at the time, however, appears to have regarded the discovery as involving any cardinal physiological principle. This epoch-making discovery was not so recognized by contemporary thought and there is little doubt that few then anticipated that the wide-bore principle would be developed later in the century and incorporated into every apparatus employing rebreathing."

J. C. M. C.

BRAY, KENNETH, AND ADRIANI, JOHN: *Do Vasoconstrictors Prolong the Action of Spinal Anesthesia?* *Urol. & Cut. Rev.* 52: 650-651 (Nov.) 1948.

"Epinephrine appears to be the only vasoconstrictor which appreciably increases the duration of anesthesia and

the intensity of motor paralysis when combined with a local anesthetic drug intrathecally. Vasopressor effects of the vasoconstrictors intrathecally are notably absent. Ephedrine, neosynephrine and oenethyl are in no way as effective when used in comparable doses in the same manner. Neurological complications are no more frequent when vasoconstrictors are used than when they are omitted." J. C. M. C.

MUSHIN, W. W.: *The Signs of Anaesthesia*. *Anaesthesia* 3: 154-159 (Oct.) 1948.

"Along the journey of anaesthesia and close to the precipice of death there is a well marked sign-respiratory arrest. . . . There is still a yearly toll of lives because this sign is not recognized. Another important sign which we are always interested to observe in our patients during abdominal operations, is that of muscular relaxation. The distance between muscular relaxation and respiratory arrest forms a good practical measure of what we mean by the 'safety' of an anaesthetic, particularly when it is given for abdominal operations. . . .

"All the so-called signs of anaesthesia are reflex motor responses, elicited by the application of stimuli to the patient. In the absence of the stimulus the sign cannot be observed. If the patient reacts to a mild stimulus like touching the cornea, we say he is near life, or that he is light. If he fails to respond to a powerful stimulus like pulling on the peritoneum, we say he is deep. The error must be avoided of inferring that a particular reflex is obtained without the stimulus for that reflex being applied. . . . There is obviously a large number of reflexes which should be utilised as signs of anaesthesia. The important thing, however, is to elicit a few of the important signs, to know why you are eliciting them, and what they mean when you see them." J. C. M. C.