

"Cyanosis, dyspnea and orthopnea disappear after spinal block, the improved muscular relaxation shortens the operating time and reduces the often severe operative blood loss. In addition, it serves as a therapeutic test—if no relief is obtained from the spinal block, vena cava ligation is contraindicated. Femoral vein ligation is then performed as a first stage and may be followed by vena cava inferior ligation at a later date.

"The most frequent complications are:

- (a) Cardiac arrest on the table (2 cases) or postoperatively (3 cases). It is essential to be prepared for such an emergency (procaine, cardiac massage) before the beginning of the anesthesia.
- (b) Postoperative acute cardiac insufficiency (2 cases), where a two-stage procedure would have been more prudent. Oxygen and medical treatment are recommended.
- (c) Renal failure may be anticipated in those cardiacs where a damaged kidney might have preceded († caused, E. G. B.) the arterial disease and the cardiac failure. One case of anuria and consecutive uremia is reported.
- (d) Pulmonary emboli may occur from a vena cava already thrombosed above the site of the ligation, or from a thrombosis of the upper extremities.
- (e) There was one peripheral embolus from the left auricle.
- (f) Acute pulmonary edema (4 patients with arteriosclerotic heart disease, 1 with mitral stenosis), especially serious where patients had edema and left failure. These patients, too, are benefited by a two-stage procedure.
- (g) Shock is especially bad in view of a low minute volume and the

danger of overloading the circulation with intravenous infusions and transfusions. Vaso-pressor drugs (Neosyneprine) are recommended.

- (h) Hemorrhage, especially after paravertebral block, where slowly oozing blood might cause serious anemia and hypoproteinemia.
- (i) Finally, thrombosis below the level of ligation, better prevented by early ambulation than by anticoagulants.

"Preoperative measures include bed rest, digitalis (if fibrillating), mercurial diuretics, penicillin and oxygen (tent) for 24 hours.

"Postoperative measures: Oxygen from the operating to the recovery room, low chloride intake, fluids by mouth and morphine, early passive movement, followed by active exercise, whenever the cardiac status allows."

E. G. B.

TILKIN, LEONARD: *Medical Contraindications to the Use of Sodium Pentothal for Narcosynthesis*. Dis. Nerv. System 12: 57-61 (Feb.) 1951.

"Despite some reports of the use of sodium pentothal in the presence of previously accepted contraindications, the general attitude is to accept the following conditions as definite contraindications: marked hypotension or hypertension, coronary disease, cardiac decompensation, myocardial damage, hepatic damage, respiratory obstruction of any type, and any gross abnormality of metabolic activity or other factors that would be generally debilitating to the patients physical condition. Thus projecting the above information to the psychiatric use of sodium pentothal for narcosynthesis, we have accepted the same conditions as contraindications. In a series of 400 interviews with 125 individuals, the breakdown of

which will be reported in a future paper of this series, we accepted candidates for pentothal interviews on the fundamental assumption that they were free from any contraindications listed above. This series was selected at random, entirely unrelated to specific psychiatric diagnosis. . . .

"[in one case] there existed the possibility of an obstructive atelectasis from the vomitus; and since that time, has caused a more careful evaluation on the part of the author to rule out even recent gastro-intestinal upset as a possible superficial cause of an irregular reaction to pentothal. . . . [A second case] made the writer aware that even conditions such as acute coryza and bronchitis that involve and impair the respiratory function must be respected, even in the healing stage, as a possible contraindication to the use of sodium pentothal. [A third case] was an example of the fact that any disease that involves the respiratory tract in any manner, even though it may be chronic in nature and allergic in manifestation, should be considered as a contraindication to the use of sodium pentothal." A. A.

DOUGLAS, G. W., AND VOSBURGH, L. F.: *Improved Pudendal Block Anesthesia with Hyaluronidase*. Am. J. Obst. & Gynec. 62: 1253-1261 (Dec.) 1951.

"Pudendal nerve block is subject to a number of disadvantages and limitations. . . . The recent introduction of hyaluronidase as an adjuvant in regional anesthesia promises to overcome many of the . . . objections. . . . Among the advantages claimed for mixtures of procaine and hyaluronidase are: rapid onset of anesthesia, wider extent of anesthesia, less tissue edema, and less accuracy required in injection of the solution. The use of this mixture might provide a far more satisfactory anesthesia, while retain-

ing the simplicity and safety of pudendal block with procaine alone. . . . Pudendal blocks in this study were divided into four categories. . . . Group I. In this control group, a critical attitude was adopted in order to bring out the undesirable features of pudendal block anesthesia with procaine alone, and thereby provide a standard by which to judge the merits of other anesthetic solutions. Thirty-eight of these blocks were carried out in primiparas, 12 in multiparas. . . . Results showed that short duration and inadequate distribution of anesthesia, edema of tissues, and poor relaxation of the patient are serious shortcomings of pudendal block anesthesia with procaine alone. Without question, individual skill of the operator had a bearing on the incidence of satisfactory results, and this is a valid criticism of the method if it is to be widely employed by physicians of variable skill and ability.

"Group II. Ten pudendal blocks were performed with 1 per cent procaine with hyaluronidase added. This small group was studied in an effort to determine the effect of the enzyme on distribution and duration of anesthesia. Eight patients delivered spontaneously, and two were delivered by low forceps. Seven were primiparas, and three multiparas. The group included eight episiotomies and one second-degree laceration. In every case anesthesia was apparent by the time pudendal block had been completed, but usually the full effect was not reached for several minutes. . . . Although this group is far too small to permit valid conclusions to be drawn, it is striking that eight of the ten cases were regarded as successful with regard to relaxation of the patient during delivery, while in only two of the ten was episiotomy repair completed under satisfactory anesthesia. In eight cases the patient complained of pain