

tion is better than constant suction. Control of the infant's temperature is important. Careful attention to maintenance of hydration and avoidance of overloading by the intravenous route is emphasized. The greatest wrong done the infant is to schedule his case late in the forenoon or at the end of a long list. The age of infant patients is no justification for poor results or high mortality rates. (*Lynn, H. B.: Special Considerations in Surgical Care of Infants, Postgrad. Med. 22: 492 (Nov.) 1957.*)

**SPINAL ANESTHESIA** During four years of private anesthesia practice, 8,633 cases were anesthetized. Spinal anesthesia accounted for 2,589 or 29.9 per cent of the anesthetics. Headache was a complication in 4 per cent of 502 deliveries and 0.5 per cent of 2,089 surgical cases. No deaths or neurological sequelae attributable to the spinal anesthesia occurred. (*Ochsner, A. J.: Use of Spinal Anesthesia in Private Practice, South. M. J. 50: 1156 (Sept.) 1957.*)

**STELLATE BLOCK** Although one of several pathologic factors may be the final precipitating cause in an attack of acute focal cerebral ischemia, vasospasm undoubtedly enhances the degree and duration of the ischemia to some extent in each case. Along with treatment of the particular local cause for cerebral ischemia should go supportive efforts to prevent focal cerebral ischemia. These include (1) sympathetic blocks; (2) correction of systemic deficits such as anemia, hypotension, cardiac failure, and obesity; (3) administration of vasodilator drugs such as nicotinic acid and nitroglycerine; (4) sympathectomy if item (1) is helpful; (5) administration of anticoagulants, and (6) administration of sedatives. (*Kirgis, H. D., and Llewellyn, R. C.: Rationale of Cervical Sympathetic Block for Acute*

*Focal Cerebral Ischemia, South M. J. 50: 1277 (Oct.) 1957.*)

**INTRAOSSEOUS ANESTHESIA** Anesthetization is achieved by injecting 0.25 to 0.5 per cent procaine (Novocaine) solution into the metaphysis of any bone at a point below the site of an elastic pressure bandage or ordinary tourniquet. Puncture of the bone is made with a short needle (Bier) fitted with a trocar. The needle is inserted to a depth of 1.5 to 2 cm. after which the trocar is withdrawn. Procaine is injected slowly at first in order to diminish the sensation of pain. Complete and deep anesthesia ensues in 3 to 5 minutes. 25 to 50 ml. of procaine is injected in operations on the upper extremity; for anesthesia of the lower extremity, 60 to 120 ml. of procaine is an adequate quantity (depending on the level of surgical interference). Intraosseous anesthesia enables an operation such as resection of a knee joint to be performed painlessly. Injected procaine solution passes quickly from the osseous veins to the superficial and deep veins of the extremity and also into the small venules, which accompany the nerve trunks. The method of anesthesia described has certain shortcomings, namely the experiencing of pain in the early stages of the procaine injection and the rapid return of sensation after the removal of the tourniquet. It is recommended that the tourniquet be released slowly. The safety and simplicity of this method coupled with the complete anesthesia of all tissues in the extremity favor a widespread use of intraosseous anesthesia. (*Fraiman, S. B.: Intraosseous Method of Anesthesia in Operations Upon Extremities and Its Anatomical Basis, Khirurgija 12: 38, 1955.*)

**ANESTHESIOLOGIST (?)** A physician is one who pours drugs, of which he knows little, into a body of which he knows less. (*Voltaire*)

The "Briefs" of Russian literature were taken from *Excerpta Medica's* "Abstracts of Soviet Medicine," which is supplied through the Public Health Service of the National Institutes of Health.