and from then on he ate and drank. He was out of bed and walking on the twenty-third day and discharged on the thirtieth day. At this time he had a slight nasality of his speech and some trouble in swallowing as the only aftereffects. Two months after the accident he was back at school. An I.Q. test done before his discharge from the hospital gave the same result as one done 3 months prior to the accident. At the present time he is neurologically and mentally normal.

The physicians who took care of this patient were residents in surgery and anesthesiology, who were in constant attendance at his bedside in the Intensive Care Unit for 7 days and nights. They were aided by consultants in pediatrics and neurology.

The duration of circulatory arrest in this case is unknown, but apnea was known to have existed for 15 to 20 minutes. We may speculate that postanoxic cerebral edema was prevented or reduced by the immediate induction of hypothermia, the deliberate overventilation (respiratory alkalosis), the intravenous use of urea, or a combination of these factors.

CORRESPONDENCE

Respiratory Arrest and Intraperitoneal Neomycin

To the Editor.—The interesting article "The action of some antibiotics on the human intercostal nerve-muscle complex," by Drs. Sabawala and Dillon (ANESTHESIOLOGY 20: 659, 1959) seems to prove that the combination of intraperitoneal neomycin with ether anaesthesia leads to respiratory paralysis. These cases of respiratory arrest known in the literature all took place during ether anaesthesia. However, I described a case of respiratory arrest, lasting for two hours, following intraperitoneal administration of neomycin during anaesthesia with thiopentone/*d*-tubocurarine/nitrous oxide/oxygen, but *without ether*, in a 47 year old woman, who underwent a gastrectomy for a perforated duodenal ulcer (*Arch. chir. neerl.* 11: 356, 1959). A few months previously this patient underwent a hysterectomy and prolapse operation. I gave that anaesthesia as well (thiopentone/*d*-tubocurarine/nitrous oxide/oxygen) but this time without respiratory difficulties.

How do Drs. Sabawala and Dillon explain the respiratory arrest due to intraperitoneal neomycin during anaesthesia without ether?

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SINGLE-DOSE CAUDAL In a group of 114 obstetric patients, single-dose caudal anesthesia was used for anesthesia for delivery. One per cent procaine and lidocaine only occasionally provided satisfactory anesthesia; 2 per cent lidocaine was satisfactory in 68 per cent of the deliveries but was abandoned because of reported high toxicity of this drug. Chloroprocaine hydrochloride was used in a 2 and also 3 per cent concentration. The results were satisfactory in 85 per cent of the administrations, the majority of the 15 per cent failures being due to technical difficulties. Of the 7 failures, 4 were due to inability to locate the caudal space and 3 followed persistent aspiration of blood, the method then being discontinued. With the use of a short needle and avoidance of giving more than 20 cc. of solution, this is a satisfactory type of anesthesia for delivery. (*Gotchel, R. P., and West, W. A.: Single-dose Caudal Anesthesia in Obstetrics, Obst. & Gynec. 14: 652 (Nov.) 1959.*)