of action of the block was 31 to 120 minutes and in 5 was over 120 minutes. In the 73 multiparas, 53 of the blocks lasted 31 to 90 minutes and two over 120 minutes. The results were good in 66 primiparas and 54 multiparas. The blocks failed in 4 primiparas and 6 multiparas. Twenty-six infants had low Apgar scores but in none could this be related to the paracervical block. There were no significant fetal or maternal complications. (*Van Praagh, G., and Povey, W.: Paracervical Block Anesthesia in Labour, Canad. Med. Ass. J. 94: 262 (Feb.) 1966.*)

PARACERVICAL BLOCK When general anesthesia or sophisticated forms of conduction anesthesia were unavailable or contraindicated, paracervical block was used for dilatation and curettage in 37 patients. Ten milliliters of either 1 per cent lidocaine or procaine or 5 ml. of 2 per cent lidocaine was placed into each lateral fornix with a standard 6-inch, 20-gauge needle at a depth of 6 to 12 millimeters. The block's effect was good in 34 cases and fair in 3; there were no failures. No significant complications occurred. The necessity of guarding against and being prepared to treat local anesthetic sensitivity is recognized. Paracervical block proved to be a convenient, safe, simple and effective anesthetic technique for dilatation and curettage, including when other anesthetic techniques were contraindicated. (*Praag, I., and Povey, W.: The Use of Paracervical Block Anesthesia for Dilatation and Curettage, Canad. Med. Assoc. J. 94: 267 (Feb.) 1966.*)

NEUROLEPT ANESTHESIA Neuroleptanalgesia was used in neurosurgical procedures with haloperidol and dextromoramide or with dehydrobenzperidol and phentanyl and supplemented with nitrous oxide and oxygen. In all cases authors used the Engstrom respirator and hyperventilation in the first hours. It was observed that the respiratory rate was somewhat slower and the blood pressure slightly decreased from the preoperative period. The brain was of small size. It is suggested that the glial cells are responsible for the development of cerebral edema and that the two analgesics used have a specific effect on the glial cells which prevents it. (*Torrelli, L., and Schiavi, F.: Neuroleptanalgesia with Predominant Use of Analgesia in Neurosurgery, Agressologie 6: 327 (May) 1965.*)

NEUROLEPT ANESTHESIA Neuroleptanalgesia supplemented with nitrous oxide and oxygen was used in 104 cases of surgery for vascular anomalies. All patients received 30 per cent glucose with 40 units of insulin and calcium chloride and potassium lactate intravenously. Various drugs were used for neuroleptanalgesia but most recently hydroxygammabutyric acid. It is stressed that in these cases additional potassium must be given preoperatively. Additional analgesia, if needed, is provided with fractional doses of pyrrolamidol. Temperature is lowered by surface cooling to 29° C. Pulse rate is slower and blood pressure 30 to 40 mm. of mercury lower than before operation. No serious complications attributable to anesthesia technique could be observed in this group of patients. There were two pregnant women anesthetized in this manner and later both delivered healthy infants. (*Perraut, C., Laborit, H., and Kind, A.: Use of Artificial Hibernation in Vascular Surgery of the Brain, Agressologie 6: 333 (May) 1965.*)

PENTAZOCINE Pentazocine (WIN 20,228) was administered to 216 postoperative patients or to patients suffering from nonsurgical pain. Thirty milligrams of pentazocine subcutaneously or intramuscularly produced analgesia equal to that of 50 to 75 mg. of meperidine or 10 mg. of morphine; 60 mg. of pentazocine provided analgesia equivalent to 100 mg. of meperidine or 15 mg. of morphine. Nausea and vomiting were very common in the postoperative patient after pentazocine but were easily controlled with antiemetics. Significant hypotension was not observed. Psychic depression and euphoria were absent after pentazocine. This is desirable in patients who should remain alert; however, morphine and meperidine are superior when psychic depression is desired. Abrupt stoppage of the drug in one patient after prolonged administration was tolerated without signs of narcotic withdrawal. (*Henshaw, J. R., and others: Pentazocine: A Potent Nonaddicting Analgesic, Amer. J. Med. Sci. 251: 57 (Jan.) 1966.*)