the CNS, techniques of anesthesia for neurosurgical operations, hypoxia and the CNS, and finally, anesthesia for neurosurgery and postanesthetic care. Each of these parts is in turn subdivided in a convenient form so the reader can consult that particular area in which he is interested. Dr. Jenkins is objective without being dogmatic. The content of the book varies: sometimes he covers areas which should be left to other monographs, such as the discussion on hypoxia, but if the objective of Dr. Jenkins was passing information, he certainly achieved this goal.

The neuroanatomy section seems longish in relation to the length of the book. A few good illustrations could have saved precious space to be devoted to certain topics now omitted. There is no reference to the concept of minimal alveolar concentration (MAC) and its place in judging depth of anesthesia. Although this is a much-abused concept, it should be discussed in a book such as this. There should also be a section on mechanisms and sites of action of anesthetic agents. The author fails to discuss concepts such as pain, amnesia and analgesia, but repeatedly stresses the importance of the ascending reticular activating system in the mechanisms of anesthesia, a role that has been overemphasized for lack of better knowledge of the complexity of the CNS. The discussion of mechanisms of neuroleptanalgesia is too speculative.

I have found this work useful, full of information, and supplied with plenty of good references on anesthesiology and the CNS, an area in which there are few books. As Dr. Jenkins states in the introduction "Much is yet to be discovered, clarified and clinically applied." A second edition should take care of present deficiencies.

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DEFINITION OF DEATH An Ad Hoc Committee of the Harvard School of Medicine was organized to study and define irreversible coma as a new criterion for death. The neurologic impairment to which the terms "brain death syndrome" and "irreversible coma" have become attached indicates diffuse disease. Function is abolished at cerebral, brain-stem, and often, spinal, levels. This should be evident in all cases from clinical examination alone. Cerebral, cortical and thalamic involvement are indicated by a complete absence of receptivity of all forms of sensory stimulation and a lack of response to stimuli and to inner need. The term "coma" is used to designate this state of unreceptivity and unresponsiveness. But there is always coincident paralysis of brain-stem and basal ganglionic mechanisms, as manifested by an abolition of all postural reflexes, including decerebrate postures; complete paralysis of respiration, widely dilated, fixed pupils; paralysis of ocular movements, swallowing, phonation or movement of the face and tongue muscles. Involvement of the spinal cord, which is less constant, usually is reflected in absence of tendon reflexes, nociceptive reflexes or flexor withdrawal. Of the brainstem-spinal mechanisms that are preserved for a time, the vasomotor reflexes are the most persistent. They are responsible, in part, for the paradoxical state of retained cardiovascular function, which is to some extent independent of nervous control, in the face of widespread disorders of cerebrum, brain stem, and spinal cord. Neurologic assessment gains in reliability if the aforementioned neurologic signs persist over a period of time, provided that there is no accompanying hypothermia or evidence of drug intoxication. If either of the latter conditions is present, interpretation of the neurologic state should await the return of body temperature to normal levels and elimination of the intoxicating agent. Under any other circumstances, repeated examinations for 24 hours or longer should be required in order to obtain evidence of the irreversibility of the condition. (Beecher, H. K., and others: A Definition of Irreversible Coma, J.A.M.A. 205: 85 (Aug.) 1968.)