made to close the chest, to make it "air-
tight." In the main, these attempts in-
clude some form of pressure or suction
method. . . . Despite the most pains-
taking closure and attempts to remove
all trapped air, irrespective of the
method utilized, the negative pressure
obtained immediately postoperatively
is temporary. In our series of cases,
42 per cent showed clinical evidence of
air in the chest on the operated side.
. . . For the past few months, we have
instituted an anesthetic-surgical tech-
nie for obtaining an air-tight closure
of the chest with gratifying results.
. . . An attempt is made to replenish
the inspired atmosphere with nitrogen
or helium at the conclusion of the
operation . . .

"Slight overexpansion of the lungs
and its continued maintenance at that
level is imperative, i.e., until the wound
is completely closed, dressing and ad-
hesive or bandages applied, and under-
water drainage established. . . . In
the last 23 cases where this closure
tehnic has been employed, the lungs
have remained completely inflated dur-
ing the entire postoperative period.
Clinically, these patients have shown
no signs of respiratory embarrassment;
aspiration of the chest has not been
necessary, and we have had no respira-
tory complications. . . . With the ex-
ception of phenomena directly refer-
able to blood loss, surgical trauma, and
the preoperative physical status of the
patient, circulatory accidents are
rarely encountered. . . . Stimulation
of the vagus nerve may be responsible
for reflex effects on respiration and
circulation which may appear before
surgery is attempted. It has occasion-
ally been precipitated by preliminary
tracheal intubation. . . . Although fa-
talities from vagal stimulation have
been known to occur, they are fortu-
nately rare, but the less serious reac-
tions interfere with the conduct of the
anesthesia and superimpose an added
burden on the patient. These reflexes
may be depressed by the preoperative
use of parasympathetic inhibitor drugs
such as atropine and scopolamine.
More recently, however, the local ap-
lication of intravenous injection of
procaine solutions has largely elimi-
nated these hazards. . . . In this series
of cases we have at one time or another
employed every anesthetic agent and
technic at our disposal with the excep-
tion of local infiltration, spinal anes-
thesia, and intravenous barbiturates.
. . . We now routinely use for induct-
ion nitrous oxide, ethylene, or cyclo-
propane, if there are no contraindica-
tions to the use of the latter agent, and
then complement the inducing agent
with ether. . . .

"Since the majority of these patients
have a marked reduction in their vital
capacity, we purposely under-premed-
icate our patients so that the threshold
of the respiratory center will not be
too greatly elevated."

J. C. M. C.

SMITH, G. F. R.: The Teaching of An-
esthesia. Anaesthesia 3: 110-112
(•July) 1948.

“All that a dental surgeon should
know could easily be given in three
lectures and this would obviate padd-
ing with details of those anaesthetics
no dentist would consider using. . . .
A nurse should certainly know some-
ting of the properties of the agents in
common use, and such theory can only
be imparted in lectures. The practical
side she can pick up in the surgical
wards and in the theatre, and here the
sister will be largely responsible for
teaching. Gas and air instruction is
already included in the C.N.B. course.
. . . At Universities one question to be
settled is whether the teaching of
physics, anatomy and physiology
should be in the hands of the profes-
sors of those subjects or left to the
anaesthetic specialist.”

J. C. M. C.