with systolic pressures of about 70 mm. Hg, which may be regarded as the optimal level." J. C. M. C.


"In the interests of historical accuracy we should render ‘honour where honour is due.’ We must pay homage to John Snow whose practical mind, so early in the history of anaesthetics, appreciated the fact that airways in ether inhalers should be ample and adequate in calibre. Dr. T. Wilson-Smith re-introduced this wide-bore principle (so long forgotten, like so much of Snow’s sound observation and advice) when modifying Clover’s inhaler. Hewitt’s fame as an experimenter and clinical anaesthetist probably placed the ‘halmark’ on the principle when he modified this inhaler, independently, some two years later. Both men recognized that the narrowness of the internal calibre of Clover’s inhaler caused an unnecessary restriction to respiration and that increased airways gave markedly improved clinical results. Nobody at the time, however, appears to have regarded the discovery as involving any cardinal physiological principle. This epoch-making discovery was not so recognized by contemporary thought and there is little doubt that few then anticipated that the wide-bore principle would be developed later in the century and incorporated into every apparatus employing rebreathing.”

J. C. M. C.


"Epinephrine appears to be the only vasoconstrictor which appreciably increases the duration of anesthesia and the intensity of motor paralysis when combined with a local anesthetic drug intrathecally. Vasopressor effects of the vasoconstrictors intrathecally are notably absent. Ephedrine, neoephedrine and epi-nephrine are in no way as effective when used in comparable doses in the same manner. Neurological complications are no more frequent when vasoconstrictors are used than when they are omitted.” J. C. M. C.


"Along the journey of anaesthesia and close to the precipice of death there is a well marked sign-respiratory arrest. . . . There is still a yearly toll of lives because this sign is not recognized. Another important sign which we are always interested to observe in our patients during abdominal operations, is that of muscular relaxation. The distance between muscular relaxation and respiratory arrest forms a good practical measure of what we mean by the ‘safety’ of an anaesthetic, particularly when it is given for abdominal operations. . . .

"All the so-called signs of anaesthesia are reflex motor responses, elicited by the application of stimuli to the patient. In the absence of the stimulus the sign cannot be observed. If the patient reacts to a mild stimulus like touching the cornea, we say he is near life, or that he is light. If he fails to respond to a powerful stimulus like pulling on the peritoneum, we say he is deep. The error must be avoided of inferring that a particular reflex is obtained without the stimulus for that reflex being applied. . . . There is obviously a large number of reflexes which should be utilised as signs of anaesthesia. The important thing, however, is to elicit a few of the important signs, to know why you are eliciting them, and what they mean when you see them.”

J. C. M. C.