distances involved in order to arrive at a more precise understanding of the problem. . . . After measurement of 200 adult skulls, 149 with teeth in normal occlusion and the remainder in malocclusion, it was found that the distance from the inferior orbital fissure to the dento-enamel junction of the second molar, hereafter referred to as the ‘needle distance,’ varied from 29 to 51 mm. If it is now considered that the distance from the gingival margin to the buccal fold may vary from 3 to 12 mm., one realizes the problem inherent in using a fixed depth of injection, whether it be 2, 2.5, or 4 cm. . . . The two variable distances, the height of the buccal fold and the needle distance, negate the value of any fixed depth of injection. In the course of our study on these skulls we found a close relation between the distances from the inferior orbital fissure to the dento-enamel junction of the second molar (needle distance) and the distance from the infra-orbital margin to the dento-enamel junction of the bicuspids, hereafter referred to as the ‘facial measurement.’ . . . Clinically, it is possible to measure the facial distance with a caliper, applying one point to the infra-orbital margin and the other to the gingival margin of the second bicuspid. The distance then is marked off on the 20 gage bent hypodermic needle with a movable rubber stop, and the insertion is made until this is opposite the gingival margin of the second molar. Using this method on a large number of patients, we have obtained excellent results.”

J. C. M. C.


“Vesalius in 1542 discovered that inflation of the lungs was necessary to life when the chest was widely opened. He was able to keep animals alive under these conditions by blowing intermittently into a reed inserted into their tracheas. . . . The first really exhaustive study in endotracheal anesthesia was made by the German surgeon, Franz Kühn. Kühn devised semi-rigid metal tubes which he passed into the trachea either through the nose or through the mouth, using a finger to guide the tube through the larynx. . . . In 1909, Metzger and Auer showed that if air under some positive pressure were blown into the trachea at its bifurcation, life could be maintained in an animal whose respiratory movements had been suppressed by curare. An endotracheal catheter of narrow hose was used, and the air was allowed to escape between the tube and the trachea. The degree to which the lungs were kept distended obviously depended on the relation between the rate at which air entered through the catheter and the rate at which it could escape through the glottis alongside the catheter. This technique was applied to clinical anesthesia by Elsberg, and has come to be known as ‘insufflation endotracheal anesthesia.’ . . . The ingenuity of such men as McKesson, Gwathney, Teter, Forreger, and Connell in this country, and of Bayle, Shipway, Mabill, and Rawbotham in England was displayed as they evolved apparatus for the administration of vapors and gases. . . . It is to the records which will be kept in the future by the rising generation of anesthetists that we must look for evidence which will enable us to form a more balanced judgment as to the optimum conduct of anesthesia for thoracic surgery.”

J. C. M. C.


“The opening of an abscess is usually an office procedure. . . . The ex-
ABSTRACTS

Brown, A. S., and Howrie, J.: **Per-**

‘‘When using cocaine solutions during anaesthesia a drug reaction occurs, in spite of all reasonable precautions, in a small but significant number of cases. . . . In an endeavour to overcome this danger it was decided to try to find a safe substitute for cocaine from among the drugs at our disposal in Japan and, if such a drug was available, to discard cocaine entirely. On consideration it was known that per-
caine (B.P.) is an efficient surface anaesthetic in concentrations of 2 per cent., having a good action on mucous surfaces, and from experience in its use in spinal and local anaesthesia, it was known to be a safe drug. Also, as far as could be found from the lit-
erature available to the authors, no cases of idiosyncrasy to the drug have been reported since its introduction. . . . The otolaryngologist was approached with a view to doing a con-
trolled series of experiments, using the 1:200 solution of percaine in 6 per cent. glucose as a direct substitute for cocaine . . . The authors have carried out a clinical trial on a series of over fifty assorted cases using the standard (1/2 per cent. percaine in 6 per cent. glucose) heavy spinal anaesthetic solution and have found it to be quite as good as 10 per cent. solutions of cocaine in every respect except one, namely that it does not provide deep vasococonstriction of the tissues. However, the surgeon (J. H.) never found this to be more than a minor inconvenience. . . . The period of anaesthesia is about an hour and a half’s duration and so avoids the necessity of ‘working to the clock’ during lists. The long period of analgesia following its use makes the initial period of recovery much more pleasant for the patient. Its action is very rapid even in the presence of severe haemorrhage, thus giving it an advantage where intranasal packs have to be inserted in an emergency. The cough and laryngeal reflexes return within forty minutes. . . . The authors have discontinued the use of cocaine solutions for all purposes and substi-
tuted the 1:200 solution of percaine in 6 per cent. glucose, for all ear, nose and throat work, as they regard the use of cocaine as no longer justified in the presence of an equally efficient and much safer drug.’’

J. C. M. C.