pert in the treatment of rectal diseases by office methods will use local anesthetic, in the form of monocaine, nupercaine, novocaine, or whatever local anesthetic is the choice of the operator. . . . Before doing anything else we should mark what looks like the spot where this abscess would head up if permitted to do so. . . . It is even a good idea to mark the lines of the incision which we intend to make after anesthesia is established. . . . The injection of the local anesthetic should be begun at a point about two inches away from the center of the site of incision. After the area is cleaned, a spot should be made on the skin with carbolic acid (phenol 95 per cent), on a wood applicator rather than with a metal probe. The wood will soak up some of the solution and make a discreet spot. When this small spot is made on the skin, the needle is then inserted into the very superficial layers of the skin. . . . Injecting as we go, the needle should be advanced with the idea of forming a complete ring of injected skin around the summit of the abscess. . . . The objections expressed condemning local anesthesia near abscesses are based on the theory that we are likely to spread the infection or get it into the blood stream. This idea got into a book and so will be found in all books henceforth.’’

J. C. M. C.


“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 percaine (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 anesthesia, it was known to be a safe drug. Also, as far as could be found from the literature 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 controlled 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 vasoconstriction 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 substituted 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.