
"We are presenting, for the first time in this country, a report on a series of 100 cases of thoracic operations performed between October, 1945, and September, 1946, with epidural anesthesia. This anesthetic is being presented for consideration as an anesthetic which gives the operator a wide-awake and cooperative patient who is able to follow the surgeon's instructions during operation. The anesthesia is accomplished by injecting the anesthetic agent into the epidural space which lies between the dura mater of the spinal cord and the bony and fibrocartilaginous boundary of the vertebral canal. The anesthesia is predominantly sensory. Thus, we have no impairment of the intercostal muscles, diaphragm, nor the accessory muscles of respiration. No special equipment is necessary for performing an epidural anesthesia. We have used various concentrations of procaine (from 1 to 2 per cent), procaine-pontocaine mixtures, all with and without adrenaline. We also used 1 1/2 per cent Metycaine on one occasion. The site of the puncture is chosen in an area between the seventh cervical and the third thoracic spines. As gravitation aids in the downward diffusion of the solution, we prefer to administer the anesthetic with the patient sitting with his back bowed and head flexed. We have used epidural anesthesia in 100 thoracic operations on sixty-six patients. In addition, there were five other patients in whom the anesthetic was abandoned. In three of these cases spinal fluid was obtained and blood was aspirated in the other two. The drop sign was used as a guide in locating the epidural space. After an analysis and comparison of the various forms of anesthetics, we are of the opinion that epidural anesthesia most closely approaches the ideal anesthesia for chest surgery."

J. C. M. C.


"It is common knowledge that penetration of palatal tissue with a hypodermic needle for the purpose of anesthesia and injection of the anesthetic solution are always accompanied by pronounced pain. The extremely tough fibrous texture of the palate resting closely against dense bone and a comparatively greater blood and nerve supply over that of the buccal and labial tissue perhaps explains this undesirable phenomenon. On the other hand, the locale for infiltration injections in both labial and buccal tissues is a structure of soft and elastic texture; it is not overrichly supplied with nerves and rests quite loosely against its supporting spongy bone. This favorable anatomic arrangement permits virtually painless piercing, penetration, and injection into normal noninflamed tissue, provided a sharp needle of proper gauge is being used. Initial painless penetration and infiltration of the highly sensitive palatal tissue can be readily accomplished, and for these reasons: The three alveolar nerves can be anesthetized at the mucobuccal fold virtually without causing pain. The terminal branches of these nerves interlace freely with the terminal branches of the palatal nerves in the mucosa and periosteum covering the entire length of the crest of the alveolar process. Thus, after the hypodermic needle pierces painlessly the appropriate portion of the mucosa in the alveolar border (innervated by the peripheral endings of the alve-
olar nerve which were previously anesthetized through an injection in the mucobuccal or labial fold), the anesthetic solution readily diffuses, partly through osmosis, into the closely positioned peripheral endings of the palatal nerve. Any supplementary anesthesia of the palate can then be readily and painlessly effected in the routine manner accepted by anesthetists. The following steps briefly describe this new approach in the anesthetization of palatal tissue: 1. Anesthetize the appropriate alveolar nerve through block or infiltration anesthesia. 2. Direct the hypodermic needle at a right angle to the labial or buccal gingival surface, as the case may indicate. . . .

3. Insert the point at the mesial interproximal space of the tooth to be operated on, exactly on a level with the highest plane of its (normal) gingival curvature. . . . 4. Now boldly advance the point of the needle until it rests against the bone structure. 5. Slowly discharge the anesthetic solution. A noticeable blanching of the palatal portion of the gingival mucosa will be instantly noticed. 6. Withdraw the needle and reinsert it into the blanched tissue (over its palatal aspect). . . . Complete the injection at this point."

J. C. M. C.


"Muscle relaxant drugs have great possibilities in clinical practice. They are dangerous drugs and anaesthetists, who are already familiar with their use and equipped with the necessary apparatus, are being called upon to administer them for the diagnosis and treatment of a variety of conditions. The perfect muscle relaxant would be a drug easily administered, in effect directly proportional to the dose, reversible in action and with no side-effects of any kind. . . . Myanesin is a synthetic drug which has muscle relaxant properties. . . .

"As an aid to diagnosis curariform drugs have been found of considerable value. In myasthenia gravis as little as one-fortieth of the normal relaxant dose will elicit an exaggerated effect, even to respiratory failure. . . . It was hoped that tinnitus aurium would prove amenable to treatment by curarising agents but these hopes have not been fulfilled. Diagnosis of the type