and blood pressure reveals that Marcy’s law does not apply during anaesthesia. Post-operative vomiting is often the basis upon which a patient judges the anaesthetic. The incidence of vomiting increased with the length of operation. Vomiting increased after ether. Blood loss varies in the same patient with different operations. Certain cases seem to show a tendency to bleed under cyclopropane.

The patient’s safety and the success of the operation are the two most important factors in the choice of an anaesthetic. From a study of these cases it would seem that these factors are best served by such agents as nitrous oxide, with trichlorethylene or pentothal. Factors of recovery and administration are best served by cyclopropane. 2 references.

F. A. M.


Analgesia or relief of pain, and anesthesia or loss of sensation, during the second stage of labor and operative deliveries are the subjects of this paper. Ethyl ether is the most widely used anesthetic in obstetrics in the United States, probably due to the low cost, low mortality, ease of administration and wide margin of safety. Induction with ether is slow, excitement is apt to occur, there is slight damage to the liver, and the drug is irritating to the respiratory tract. It should not be used for patients who have upper respiratory tract infections, pulmonary disease, acidosis, diabetes or increased intracranial pressure. Considerable nausea and vomiting follow its use and uterine inertia follows increased depth of anesthesia.

Divinyl ether may cause liver damage. Long anesthesia is not particularly successful. Induction is quick and nausea and vomiting are less than with ethyl ether. The use of chloroform in the United States is limited because of its toxic effects on the liver and heart and the weakening effect on the force of uterine contractions.

Nitrous oxide is used extensively. When adequate oxygenation is provided there is no effect on the child. The chief drawback of nitrous oxide is the limited depth of anesthesia which is possible. Ethylene produces more relaxation than nitrous oxide. Its disadvantages are those of nitrous oxide. It is explosive and nausea and vomiting are increased during the recovery period. Cyclopropane, of all the inhalation anesthetics, is preferred by the author. Explosibility, complicated apparatus, a trained anesthetist, possible effect on the heart, as well as nausea and vomiting, are some of the drawbacks to the use of cyclopropane.

Nitrous oxide and ethylene have little effect on uterine contractions. All other inhalation anesthetics tend to diminish the contractions. Aspiration of vomitus is one of the greatest hazards of inhalation anesthesia and efficient suction apparatus should be part of the delivery room equipment.

Intravenous anesthesia with pentothal sodium is popular, especially for low forceps deliveries and for cesarean sections. Combined with local anesthesia and withholding the barbiturate until actual delivery protects the baby from respiratory depression. Intravenous pentothal anesthesia is not satisfactory for spontaneous delivery.

Caudal analgesia is satisfactory and pleasant when it is given properly. Deaths have been directly attributed to the use of caudal analgesia and non-fatal complications have been reported. Trained personnel, special apparatus, and the high cost of continuous caudal anesthesia, as well as the possible dangers, make it unsuitable for the average woman in labor. “A review of the literature should easily convince
one that spinal anesthesia is the most
dangerous of all anesthetics for preg-
nant women."

Local anesthesia, it is generally
agreed, is the safest for persons with
serious ailments. It seems reasonable
that it is also safest for all those who
require surgery. There is practically
no mortality resulting from the method.
No pulmonary complications can be di-
rectly attributed to the procedure of
local infiltration anesthesia, nor are
there local or general complications.
The technic is simple and may be car-
ried out in either the hospital or the
home. The liver, lungs, heart, circu-
latory apparatus and central nervous
system are not adversely affected. The
physician carries out the procedures
himself. Blood loss is negligible, post-
operative symptoms are rare and pa-
patients are usually able to take liquids
and carbohydrates during and after
the procedure. The action of the
uterus, the abdominal wall and respi-
ration are unaffected. Haste is not
necessary, tissues are handled gently
and wound infection is reduced. The
method is inexpensive. Asphyxia of
the child does not occur. Not all women
can be delivered with local infiltration
but there are few limitations. More
widespread use of this form of anes-
thesia will reduce both the maternal
and the fetal mortality and morbidity.
22 references.

F. A. M.

Hershenson, B. B., and Brubaker, E.
R.: Scopolamine and Apomorphine
53: 980-995 (June) 1947.

In a series of 500 patients at the
Boston Lying-in Hospital, apomor-
phine and scopolamine have been used
to produce amnesia and analgesia in
labor. Scopolamine hydrobromide in
fresh soluble tablet form is used. It
may be administered by any route;
the duration of effect is about two
hours. Apomorphine HCl is com-
paratively unstable in solution so
fresh solutions are prepared daily.
The sedative dose of apomorphine has
not been definitely established and
varies greatly. The delirium induced
by scopolamine is completely controlled
by subemetic doses of apomorphine.
The amnesic effect of scopolamine
do not appear to be potentiated by
apomorphine, but the analgesic effect
does seem to be potentiated.

The method compares favorably
with other methods employed in the
past; it may be used in conjunction
with other known and accepted pro-
cedures of analgesia and amnesia. The
third stage of labor does not seem to
be affected by the medication. No
demonstrable depressant effects on
either full-term or premature infants
were noticed. Postpartum respiratory
complications were reduced. Other
complications were no greater than oc-
cur in a corresponding group of non-
premedicated obstetric patients. 20
references.

F. A. M.

Macintosh, R. R.: Technique of
Laryngeal Anaesthesia. Lancet 2:
54-55 (July 12) 1947.

Anaesthesia of the larynx with co-
caine or one of its substitutes is an
integral part of laryngeal intubation
or bronchoscopy. The usual ways of
anaesthetising the larynx are subject
to criticism because of the difficulty of
depositing the solution on the inac-
cessible larynx and trachea. An easy
means of anaesthetizing the air pas-
sages was sought and an apparatus de-
vised.

"The soft rubber tube of the atom-
izer I use is identical with Magill's
endotracheal tube for infants, size 00,
with a nozzle on the end. It is passed
directly and easily through the nares.
After passing the soft palate the tip
is directed by the natural curve of