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-
laratory 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-
ients are usually able to take liquids
and carbohydrates during and after
the procedure. The action of the
uterus, the abdominal wall and res-
piration 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.

HERSTH ESON, 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 amnestic effect of scopolamine
does 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:
34–55 (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
the tube towards the glottis, which can thus be sprayed readily. When this has been done an endotracheal tube can be passed readily through nose or mouth either blindly or by direct vision. To prevent siphoning, the glass container of the spray hangs lower than the nozzle; and, since the glass container always hangs downward, the spray can be held in any position. . . . I use a weaker solution of cocaine than that generally advocated. Analgesia from a 3–4 per cent solution is slightly slower in onset and shorter in duration than from the 10–20 per cent solutions commonly used, but otherwise is equally effective. One cc. of 10 per cent cocaine is placed in the container, and 2 cc. of tap water is added. I usually use the lot—100 mg. of cocaine hydrochloride. . . . A cough or interruption of the patient’s regular breathing is a sure sign that the spray has found its target. . . .

“If bronchoscopy is to be performed, the nozzle is directed through the co-
cainized larynx well down into the trachea. The bulb is squeezed on inspiration to ensure that the inspiratory air stream carries the spray at least as far as the carina. Using this technique, members of this department have sprayed themselves and passed endotracheal tubes blindly on themselves without any difficulty.” 3 references.

F. A. M.


Anesthetics were administered during 3 phases of surgical treatment of 370 chronic or “old” poliomyelitis patients. The operations were done by Harvey E. Billig, M.D., of Pasadena, California. The first phase included 71 cases of surgical nerve motor axon interruptions. The anesthesia for this phase was mainly cyclopropane and oxygen and operations lasted from one to four hours. One hundred and ninety-five cases were treated by “manual manipulation.” In this second phase the patient is shaken severely and there is heavy pressure when the thorax, back and abdomen are worked on. The third phase consists of 104 patients; 96 of them received pentothal sodium and 8 small children were given ether. In this phase a pneumatic drill is used and the explosion hazard explains why pentothal is the anesthetic of choice.

The poliomyelitis patient is flabby and weak-muscled, his heart muscle is flabby as evidenced by the fact that bradycardia under cyclopropane and oxygen anesthesia is not common. The pulse rate increased steadily in rate after an hour or so of anesthesia. Weakened muscles of respiration and scoliosis with twisting of the thorax on the abdomen are common. Most poliomyelitis patients are tense and sensitive. Because of these factors these patients may be considered only as fair risks as far as anesthesia is concerned. Medication should be minimal. Nembutal, 100 mg., the night before surgery and again one and one-half hours before surgery was given to the adults. A hypodermic of mor-
phin 12 to 16 mg. and atropin 0.3 mg. to 0.4 mg. was given one hour before surgery.

Cyclopropane worked well for the operations in the first phase. Sixty-three of 110 patients developed excessive vomiting lasting four to twenty-four hours. Cyclopropane and oxygen was not adequate for the operations in the second phase where the procedure interfered with breathing and prevented smooth anesthesia. Stridor and laryngospasm developed. Combinations of nitrous oxide or ethylene with ether after cyclopropane induction made for smoother anesthesia and