be unsuitable for seriously wounded patients. It may be used, however, if there is no hemorrhage in good risk patients with wounds of the rectum or in older injuries after circulatory adjustment has been made. 4 references.

F. A. M.


Much progress has been made in the investigation of vaso-motor spasm in the limbs since Lerche’s paper in 1921 on the sympathetic enervation of the limbs. The author confines his discussion to the lower limbs. A review of the anatomy relevant to the subject precedes the discussion of clinical material. Since the cutaneous sensation in the feet is supplied from the third, fourth and fifth lumbar and the first and second sacral roots, the author finds it impossible to believe that a low spinal can be relied upon to block the sympathetic nerves to the lower limbs.

The writer has used a block of all segments up to the fourth dorsal without using a preliminary sedative and without using analeptic drugs. In all cases where a skin temperature elevation was obtained, lumbar sympathectomy later proved efficacious. Sedatives, anesthetics or natural sleep will effect a temporary sympathetic release which will give a rise of skin temperature. For that reason sedatives are omitted before the blocks. Analeptics are omitted in order that the full effect of paralyses of the sympathetic nerves may be observed. The temperatures of the feet are measured by the skin thermometers attached to the dorsum of the foot.

Spinal analgesia is obtained as high as the 4th dorsal segment. The Howard Jones method, using 1/1000 or 1/1500 nupercaine is employed. Care is taken in all details which could affect the skin temperature. The anesthetist should be satisfied that the cardiovascular system of the patient will withstand the stresses placed upon it by a high spinal analgesia without the use of analeptic drugs. Gangrene of the leg or foot may be precipitated if organic disease of the arteries is present. 7 references.

F. A. M.


Fear of pain undoubtedly deters patients from seeking dental treatment. The purpose of analgesia in dentistry is to reduce or eliminate pain. The use of conduction analgesia greatly extends the scope of oral surgery, but certain precautions must be observed to get the best results. Asepsis is important. Prevention of syncope, or, when it occurs, prompt treatment, is important. Although there are no certain means of averting toxic reactions to the local anesthetic, premedication with barbiturates probably has some effect in guarding against them.

Of the inhalation anesthetics useful in producing dental analgesia, chloroform, because of its high toxicity, has been discarded. Ether is not suitable for analgesia because of its pungency. Vinesthene is difficult to control because of its volatility. Cyclopropane is so potent that it is difficult to avoid anesthesia. Ethyl chloride is considered to be a toxic and dangerous drug but has been used extensively for analgesia. Nitrous oxide with oxygen or with air is in many ways superior to other inhalation agents. Trichlorethylene has recently been used for both analgesia and anesthesia shows great promise in dental work.

Premedication is of great help, especially when nitrous oxide with air is to be used. With any form of analgesia