
Some phenomena occur so rarely during anesthesia that no one anesthetist can form a correct evaluation of the signs. If each anesthetist publishes his experience, eventually correct assessment may be made. On four occasions extra systoles occurred for the first time during nitrous oxide-oxygen-ether anesthesia. Each of the 4 patients died of sudden cardiac failure within the first five days after the operation. In none of the cases were cardiac abnormalities detected before operation. Extra systoles began after the operation had been in progress for twenty minutes. Extra systoles which have been discovered before operation always disappear when anesthesia becomes established. Extra systoles which occur during trilene or cyclopropane anesthesia are not of grave prognostic significance.

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With the anesthetist taking a larger part in pre- and postoperative care than has been possible in the past, advantage could be taken of his special training in sedation, in the relief of pain, intravenous technics, and in the administration of oxygen and other gases. By extending the teamwork of the operating-theatre and increasing the responsibility of the anesthetist, students should be attracted to the specialty. The overworked surgeon should welcome competent help in the preparation and aftercare of his cases.

By assuming these responsibilities the anesthetist would be required to study problems such as nutrition, physiology, pathology and other phases—relevant to the surgical patient. The preoperative examination should include an evaluation of the problem of rest and exercise. The role of proteins and the various vitamins in the nutritional status should be considered. The condition of the blood and understanding of the many factors related to blood transfusion should be studied.

Resumption of normal conditions after anesthesia should be the concern of the anesthetist. The use of fluids and their effects in the postoperative period requires consideration. Fluid loss and replacement as well as adjustment of body heat should be the concern of the anesthetist. Thorough understanding of later complications such as atelectasis and pneumonia and the predisposing causes should be part of the anesthetist’s responsibility. Thrombophlebitis and pulmonal embolism require special study. Prophylaxis as well as treatment of these conditions by the anesthetist as well as application of other special knowledge of postoperative complications should benefit the patient, help the surgeon, and bring greater interest in the specialty of anesthesia. 9 references.

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The anesthesiologist can often help the urologist in the diagnosis of rupture of the bladder or vesical neck during transurethral prostatic resection. Certain rather characteristic signs may be seen. When spinal or block analgesia has been given, the most frequent symptom of rupture is sudden, severe abdominal pain. This pain may be generalized, limited to the lower abdomen, or may be referred to the precordial area. Rigidity and tenderness