
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.

F. A. M.


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 pulmonary 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.

F. A. M.


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 pericordial area. Rigidity and tenderness
of the abdomen may be found. During light general anesthesia there may be tenseness, movement of the limbs and increased or irregular respiratory activity. Sudden changes of the pulse rate and blood pressure may occur. When a large amount of fluid is extravasated symptoms of acute shock may be seen. Small amounts of escaped fluid may cause a rise in blood pressure. Although some of these signs may be caused by coronary occlusion, when they occur during transurethral prostatic resection, accidental perforation of the lower urinary tract must be strongly suspected.

F. A. M.


To estimate the marked effects of pain relief in cesarean section, 120 consecutive cases were reviewed. All necessary preparation of the patient and operating personnel was done before the patients were anesthetized. Cyclopropane was used in 114 cases. When the body of the uterus is being opened the anesthetic gases are expelled from the breathing system to guard against tissue saturation. One hundred per cent oxygen is substituted and the mother's respiration is controlled by pressure on the breathing bag until delivery of the baby and the cord is clamped. The anesthetic is again administered and surgical anesthesia is maintained thereafter.

There was one postoperative maternal death. The patient had a cretin pelvis and extreme toxemia of pregnancy. She died four hours after delivery. The baby required resuscitation but survived. One instance of severe blood pressure fall and three instances of arrhythmia or tachycardia occurred. One patient developed broncho-pneumonia three days after operation.

Two infants of mothers having severe toxemia and one six weeks premature infant with syphilitic involvement died. Eleven infants required artificial respiration, oxygen and tracheobronchial toilet. Fourteen sleepy babies responded without artificial respiration. The anesthetic drug cannot be considered free from blame in some of these cases. 7 references.

F. A. M.


When there are contraindications general anesthesia should be provided for persons who wish it for oral surgery. Nitrous oxide anesthesia is widely used for oral surgery because it is safe, easy to administer, rapid in action and causes little postoperative distress. It is especially suitable for children, for multiple extractions and in the presence of edema or infection. The type of patient, the nature of the proposed operation and the experience of the anesthetist and of the operator should all be considered in the selection of nitrous oxide for anesthesia in dentistry. Premedication insures smoother anesthesia. Too light anesthesia causes complaints from the patient. Prolonged lack of oxygen may cause permanent damage. To use nitrous oxide anesthesia successfully requires understanding of the principles of inhalation anesthesia.

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Few, if any, well controlled studies have been reported on the effect of anesthetic agents on the propulsive motility of the small intestine in the