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 and 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.

F. A. M.


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
intact animal. Such a study was made by the authors. Two types of experiments were made on dogs previously fasted twenty-four hours. In the first group Macht's technic was followed. Charcoal (40 cc. of 10 per cent suspension in 10 per cent gum acacia) was given by stomach tube. The anesthetic agent was administered five minutes later. Ten animals were used for each of the anesthetic agents studied. Thirty minutes after intubation the animal still under the effect of the anesthetic was killed by cardiac puncture. The distance traversed by the charcoal mixture was measured in the small intestine.

In the second group the animal was first anesthetized, and abdominal incision was made over the region of the duodenum. The duodenum was exposed and 1 cc. of the charcoal mixture was introduced by means of a hypodermic syringe. Care was taken to handle the intestine as little as possible and the abdominal incision was closed. Six dogs each were used for each of the anesthetic agents studied except with ether. Ten animals were used for ether studies. After thirty minutes these animals were sacrificed and the distance traversed by the charcoal mixture was studied. The anesthetics used for the studies were: chloroform, cyclopropane, ethylene, ether, nitrous oxide, nembutal (35 mg./Kg.), pentothal (30 mg./Kg.), amytal (60 mg./Kg.) and barbital (300 mg./Kg.).

With the first group of dogs the agents depressed the propulsive motility of the small intestine in the following order: chloroform, nitrous oxide, cyclopropane, ethylene, ether, pentothal and nembutal. In the second group the order of depressive action was: barbital, ether, amytal, nembutal, chloroform, pentothal, ethylene, cyclopropane and nitrous oxide. It is difficult to evaluate certain of the results such as those obtained with nitrous oxide. In one series nitrous oxide caused the greatest, and in the other the least depression. No adequate explanation for this finding is apparent. It has been shown in other experiments that anoxic anoxia has no appreciable effect on the propulsive motility of the small intestine in dogs. It may be concluded, therefore, that whatever effect nitrous oxide had on the propulsive motility of the small intestine the concomitant anoxic anoxia presumably was not an important factor.

The clinical significance of these studies lies in their relation to common postoperative complications, such as nausea, vomiting, distention and gas pains. It would appear from these and other studies that the depressing effect of anesthetic agents on gastrointestinal musculature is probably not the decisive factor in postoperative complications. The type and duration of operation as well as the care in handling of the intestines are all presumably important factors. 18 references.

F. A. M.


Unlike most transthoracic operations the lung need only be partially collapsed for transthoracic gastrectomy. Relaxation of the abdominal muscles is of major importance as tension of those muscles may force the abdominal contents up into the thorax. This may cause inconvenience to the surgeon, especially during closure of the diaphragm. Quiet breathing in addition to relaxation is necessary. This may be accomplished by the anesthetist controlling the respiration for the patient. Should the pleura of the opposite side be opened the respirations must be carried on entirely by the anesthetist. The use of cyclopropane