
Skepticism was the first reaction to continuous caudal anesthesia but reassurance of neurologists and neurosurgeons, and the encouragement of the obstetric nurse persuaded the author to try this technie for obstetric anesthesia. First attempts were highly unsuccessful. As technical difficulties were overcome the incidence of failures decreased; as the advantages became more apparent improvement and continuation of efforts were decided upon. In a group of 275 cases no fetal or maternal deaths were attributable to the caudal block. Metyectine 1.5 per cent in Ringer's solution was used in all cases. Shortening of labor and relief of pain resulted. In a second series of 1,065 deliveries, 1,003 were done under caudal anesthesia with only 2.5 per cent failures as compared to 23 per cent in the first group. One fetal death in the second series was attributed indirectly to the anesthesia; only 38 cc. of solution was used with anesthesia reaching to the third dorsal level. Circulatory depression and anoxia of both mother and fetus followed. One maternal death occurred. A caudal block was started in an obese gravida-five in premature labor with ruptured membranes and left saphe nous phlebitis with multiple varicosities. The caudal block was started with the patient in the knee-chest position because of her obesity and an obscure sacral hiatus. Metyectine, 30 cc. of 12.5 per cent solution, gave complete relief of pain. One-half hour later the patient complained of severe pain which she did not locate, and immediately after this a convolution started. Blood pressure was 134/76. Respiration were slow and labored. She was delivered immediately of a baby who died ten minutes later. Blood loss during the delivery was replaced with two units of plasma. Oxygen and stimulants were administered but the patient died two hours later without regaining consciousness. Autopsy revealed no penetration of the dural sac and no pulmonary embolism.

Although seldom needed all of the safeguards, oxygen, plasma, ephedrine and intravenous barbiturates as well as coramine, caffeine and a sterile spinal needle should be ready. Postpartum care is simplified following caudal anesthesia and labor most nearly simulates labor as nature intended it to be. 3 references.

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The present attitude of taking anesthesia for granted must be abandoned in order to comprehend the tremendous significance of the introduction of surgical anesthesia. The surgeons as well as the patients suffered from the horrors of operation without anesthesia. The presence of pain was a barrier to the development of surgery as a science. Surgeons throughout the centuries endeavored to find some means of alleviating pain. In prehistoric and classical times drugs were used to induce sleep and deaden pain. The true story of anesthesia began in 1772 with Priestley's discovery of nitrous oxide. Many hypotheses and experiments contributed to the history of anesthesia before Morton's demonstration in 1846. Some historians have come to disregard the controversy over the discovery of ether and to interest themselves in the development of anesthesia, the spread of its use and the emergence of its various branches.

New developments in anesthesia give promise that the future will bring even