shortly after the operation that he could not move any part of his left upper extremity. He was seen by Dr. F. H. McKay (Dept. of Neurology) who found ‘all sensations present in the left upper extremity with complete motor loss in hand, wrist and forearm, the only exception being a flicker of movement in thumb flexion.’ He suggested that ‘an organic basis due to compression from a very tight tourniquet (applied before admission to check bleeding from the left basilic vein) might be held responsible but that nevertheless a large functional (suggestive) element must be present.’ All muscles of the left upper extremity responded well to Faradism and there was no reaction of degeneration. Function quickly returned to this patient and within months he was working full time again.

“In the sciatic block series there was one case of osteochondritis dissecans of the ankle which gave an excellent final result after removal of the loose fragment of bone and cartilage. Another case of fracture dislocation of the ankle suffered redislocation due to too early unsupported weight bearing. This patient, a luetic, had a fair final result after reconstruction of the ankle joint. Suppurative arthritis occurred in a case of simple fracture dislocation of the ankle. The reason for this complication was unknown and a fair final result was achieved after ankylosis of the joint. In a case of spiral fracture of the tibia and fibula gangrene of the lower leg and foot occurred postoperatively necessitating amputation seven inches below the knee. The gangrene here was attributed to traumatic spasm of the popliteal artery and its collaterals. It is not believed that any of these complications could with fairness be attributed to the nerve block. As regards the degree of anesthesia obtained, it was complete in all but five cases of the Brachial series. . . . In the sciatic block cases, slight complaints were registered in 5 cases, all during the manipulation of the fractured bone ends into position. As soon as the manipulation had ceased there was no further complaint. This leads one to suspect that the cause of the complaints might well be the feeling of crepitus which, though unpleasant, is not painful. . . . It is probable that heavier sedation in these cases would have completely eliminated the slight complaints noted.”

J. C. M. C.


“In a previous communication, I reported the results of procaine injection therapy in a series of acute ankle injuries without fracture observed aboard a carrier during World War II. This series has been subsequently increased to sixty-nine cases, and these form the basis of this report. Sixty-five of the sixty-nine patients were seen in an average period of ten hours after their injury occurred. . . . The initial injection of procaine gave an excellent result in fifty-six cases, or 86 per cent, of the series. These men all returned to full work immediately, remained free from pain, and experienced no subsequent disability. One patient obtained only a fair result, graded at 50 per cent improvement. He was subsequently treated by a supportive dressing and within three days all symptoms had disappeared. The remaining eight patients all received immediate relief following injection, but there was a recurrence of the initial pain and disability in from four to twelve hours. All of these patients originally complained of severe or very severe pain, and five were in the group with bi-
lateral ankle tenderness. Reinjection of these eight patients within six to twenty-four hours after the primary infiltration gave an excellent and permanent result in four, a fair result in one, and was a failure in three. A careful review of these three cases disclosed that a fissure fracture of the os calcis had been overlooked in reading the wet plates in one, a fracture of the astragalus in the second, and a very extensive ligamentous injury in the third. . . . The additional four patients, first seen from thirty-six hours to ten days after their injury, were all treated by injection after the possibility of bony injury was excluded. An excellent result was obtained in one, a fair result graded at 50 per cent improvement with two injections was obtained in two, while there was no benefit in the fourth. It seems well established that maximum results may be expected with injection therapy only in those patients seen within twenty-four hours after injury.” 13 references.

J. C. M. C.


“We are reporting a series of 118 consecutive deliveries under spinal anesthesia. We have worked independently and these cases represent approximately one-third of the patients delivered by us over a two year period. . . . We routinely use outlet forceps and episiotomy in the delivery of primipara, or in patients of any parity where the perineal tissues are retarding delivery of the head. Spinal anesthesia was chosen in these cases because it is the anesthesia which most facilitates delivery; the operative procedure was in no case made necessary by the use of spinal. We would use spinal in many more cases which deliver spontaneously, except for the fact that we have not yet learned how early spinal anesthesia can be introduced in multipara, and so are unable to use it because we misjudge the rate of progress in labor. . . . It should be emphasized here that spinal anesthesia is not to be used for cases requiring version. This is because the regular uterine contractions of labor continue with undiminished tone and so render such maneuvers extremely dangerous, as well as difficult. . . . There were no maternal deaths in the series. Only one patient showed a degree of shock which necessitated active treatment. In this case, it followed a long manipulative delivery and occurred three hours after the introduction of the anesthesia, and cannot be considered as due to the type of anesthetic. . . ." "Smaller amounts of drug than are used for even the lowest abdominal surgery will give obstetrical anesthesia lasting from 2 to 4 hours. The drug is given in not more than one to one and one-half cc. of liquid vehicle, with no barbotage. It is introduced low in the spinal canal—between L 3 and 4 or even between L 4 and 5—while the patient is in such a position that her hips are lower than her shoulders. The patient’s head is kept elevated on a pillow at all times after she is turned on her back. In a few cases these precautions will keep the anesthesia so low that labor pains will be incompletely relieved. Anesthesia will still be found adequate for any type of pelvic delivery and repair, and will last from 2 to 4 hours. The number of infant deaths, three, is large for 118 deliveries. . . . None of these deaths can in any way be attributed to the type of anesthesia. Of the remaining infants delivered, only two were cyanotic enough to cause the obstetrician to use restorative measures. Both of these responded promptly to