clopropane, or by a combination of these causes. Controlled respiration, which implies the occurrence of apnoea in accordance with these principles, has been developed in recent years mainly as a solution to two problems in inhalation anaesthesia: the production of relaxation with cyclopropane, and the control of the respiratory disabilities which complicate thoracic surgery.

"The controlled-respiration technique greatly enlarges the clinical usefulness of cyclopropane, but this does not justify the use of this agent in cases more satisfactorily dealt with by non-inhalation methods, e.g. in the muscular patient requiring profound relaxation over a long period and for whom local or spinal analgesia is not contra-indicated. Crafoord has pointed out that the muscles of respiration are put completely at rest during this type of anaesthesia. This is in complete contrast to the laboured movements and active expiration usually associated with semi-closed methods. The possible influence of each of these factors on the occurrence of post-operative pulmonary complications is worthy of investigation. Further blood-carbon-dioxide studies during controlled respiration would also be of interest. In the present state of our knowledge it would seem that the minimal amount of anaesthetic which will produce satisfactory operating conditions is, in the majority of cases, the best amount to use. This is true for controlled-respiration anaesthesia, and inadvertent overdosage through failure to estimate depth correctly may be one of the causes of some of the untoward post-operative circulatory effects. . . . There can be no doubt that efficient controlled respiration is wholly preferable to inadequate spontaneous ventilation, and offers an effective solution to difficulties which often arise from this cause during inhalation anaesthesia."

13 references.

J. C. M. C.


"To-day there is an increasing emphasis on the rehabilitation of the patient after operation. . . . At the outset of his career, the attention of the anaesthetist is focused almost entirely on the actual administration during operation. With increasing experience he should be able not only to provide satisfactory operating conditions for the surgeon, but also to keep constantly in mind the convalescent period and end-result. A prophylactic attitude can do much to prevent or minimize complications; and its cultivation is of the first importance. The application by the anaesthetist of a special knowledge of post-operative complications should benefit the patient, help the surgeon, and bring a wider interest to the specialty." 22 references.

J. C. M. C.


"The discovery and final establishment of inhalation anaesthesia as an integral part of surgical practice was partly the inevitable outcome of scientific research, partly the result of vagaries of circumstances. Researches on pneumatic chemistry and the physiology of respiration during the seventeenth and eighteenth centuries prepared the way for Joseph Priestley’s discovery of oxygen (1744) and for Lavoisier’s elucidation of the nature of the respiratory process (1774–85). . . . Therapeutic inhalation was principally studied by the brilliant circle of men whom Priestley had drawn around him at Birmingham. In 1792 Thomas Beddoes . . . decided that pneumatic medicine ought to be systematically and intensively studied. . . . In 1798 Beddoes was looking for a superin-