the patient stops counting or ceases to carry on a conversation. By slow administration a smaller amount of ‘pentothal’ suffices. . . . During the remainder of the operation only sufficient ‘pentothal’ is given to prevent the patient from fully regaining consciousness. If the patient opens his eyes or moves his head a small amount of ‘pentothal’ is injected unless the operation is nearly completed. By discontinuing administration of ‘pentothal’ after closure of the peritoneum most of the patients were awake before leaving the operating room . . . . We have found the routine combination of spinal and ‘pentothal’ a useful and pleasant anesthesia, and the result of several thousand administrations indicates that the margin of safety has not been appreciably lowered.’’ 19 references.

J. C. M. C


During recent years single-stage operations have increasingly supplanted multiple-stage techniques for the operative eradication of intestinal cancer. With the use of less toxic anesthetics and especially with extended spinal anesthesia associated with inhalation of oxygen, and the slow transfusion or infusion of blood, saline, dextrose, amino acids or gelatin solution, prolonged and very extensive operations may be performed upon the intestinal tract with little shock or serious depression. For spinal anesthesia, I use a mixture of 12 to 15 mg. of pontocaine with 80 to 100 mg. of procaine dissolved in 2.2 to 2.5 cc. of distilled water. This is injected through the first or second lumbar interspace and the upper part of the body instantly elevated 5 to 10 degrees for the first ten minutes or until the drug has become fixed. Usually this will give anesthesia of the abdominal region lasting for three to four hours. This may be prolonged by the free use of local and splanchnic anesthesia or the intravenous use of sodium pentothal.”

J. C. M. C


“This report covers 100 consecutive cases of cataract extraction under sodium pentothal anesthesia. While this may sound fantastic, we have not had a single unsatisfactory result. . . . The average dose is from 1 to 2 grams —usually less than 1 gram. . . . At 9 p.m., the night before operation, the patient receives 1½ grains of nembutal, and one-half hour before operation, 7/100 grains of atropine subcutaneously. In the operating room 2 minims of 4 per cent cocaine solution is instilled in each eye, and a mydriatic of choice. The eye is then prepared for operation, and on its completion sodium pentothal is administered. The average individual counts up to about twenty when sleep is produced. If there is any reaction such as a sneeze or spasm when the conjunctiva is grasped, we wait a few moments and push the sodium pentothal until relaxation is complete. . . . The end result is the important thing, and under this procedure the results have been so much better than formerly as to leave no argument.”

J. C. M. C


“The choice of intravenous anesthesia in anorectal surgery must be based on its advantages and disadvantages compared with other methods. . . . In the last six years, I have done
more than two thousand anorectal operations under ‘pentothal,’ with an average of \(\frac{1}{6}\) grams per patient. . . . The duration of the operation in most cases has been less than 30 minutes. All of these patients received a preoperative hypodermic of morphine grains \(\frac{1}{4}\) (except those known to be allergic to morphine), atropine grains \(\frac{1}{6} \text{gr} \), one hour before operation. . . . There have been no fatalities in this series of cases. . . . Postoperative nausea and vomiting have occurred in a small per cent. In these cases, the preliminary morphine was proved to be the cause of nausea and vomiting in most cases. When the morphine was left off or ‘demerol’ substituted, the nausea and vomiting usually ceased. . . . To the group of men to which I belong, who do their anorectal surgery with the patient in the flexed ventral prone posture, breathing in some cases is not so easy as in other postures and airways occasionally have to be passed. . . . In the ventral prone flexed posture, the point of puncture of the veins on the front of the forearm and elbow is best brought into view by extending the arm and forearm upward by the side of the head in line with body and then rotating the arm outwards. This usually brings all the veins on the ventral surface in the region of the forearm and elbow in view and makes them easily accessible to puncture. . . . ‘Pentothal’ sodium will not produce as complete muscular relaxation in some cases as spinal, but I have found muscular relaxation sufficient for all anorectal operations without adding any other anesthetic agent other than the preoperative hypodermic one hour before operation. . . . Curare has been added in a few cases, but not frequently enough to evaluate it. . . . ‘Pentothal’ is not suitable for office procedure. . . . In prolonged abdomino-perineal operations, it is most suitable in combination with spinal.”

J. C. M. C.


“Those patients requiring hospitalization were treated under general and local anesthesia, each case receiving the anesthetic indicated for the particular patient’s condition. In the use of local anesthesia, infiltration and block injection methods were used indiscriminately. Choice was governed by the type which would produce the most profound anesthesia. Second and third division block anesthesia, when indicated, was used for reduction of fractures of the upper and lower jaws. The anesthetic of choice in the problem of extractions was the mandibular block. For extraction of the maxillary teeth, infiltration was used. . . . In minor operations where regional anesthesia is not required and in cases involving the presence of infection in the area through which the needle is to pass, maxillary block anesthesia is obviously contraindicated in favor of some other anesthetic approach.”

J. C. M. C.


“A survey of New York Lying-In Hospital records of patients that aspirated gastric contents during obstetric anesthesia revealed the following different diagnoses: suffocation, massive atelectasis, partial atelectasis, disc atelectasis, pulmonary infarct, aspiration pneumonia, bronchopneumonia, lobar pneumonia, virus pneumonia, atypical pneumonia, tuberculous pneumonia, pulmonary tuberculosis, fungus infection, pulmonary metastasis, drowned lung, cardiac failure, pulmonary edema, and paroxysmal tachycardia. Obviously, a better understanding of this condition is wanting. . . . There