into a condition of cyclopropane shock. Once this condition develops, it is extremely difficult to combat. Many patients develop postoperative psychosis following the administration of cyclopropane. Anesthetists who deny that such things happen following the administration of cyclopropane, simply have not followed their patients to the postoperative wards. Nitrous oxide-oxygen induction with oxygen-ether maintenance by the endotracheal method is the safest of all anesthesias for major thoracic operations. If the patient is suffering from suppurative disease of the lung, extreme vigilance must be maintained at all times to prevent respiratory obstruction from developing. The patient must be draped in such a manner that the anesthetist can see into the open chest at all times. He can gain more information regarding the patient’s condition by watching the diaphragm than he can in any other manner. Spinal anesthesia is contraindicated in all thoracic operations, regardless of the ability of the anesthetist. Patients undergoing operation on the heart and pericardium should be handled in the same manner as patients undergoing any other major thoracic surgical operation.

Spinal anesthesia may be used for most operations below the diaphragm provided the patient is a good operative risk and a safe dose of the anesthetic agent is used. Most major surgical operations outside of the chest can be carried out using regional methods provided the anesthetist and surgeon are extremely careful and painstaking in their techne and provided complete cooperation can be obtained from a well premedicated patient. Procaine has many uses other than for nerve blocks preceding surgical operations. Simple infiltration for pleurisy is one of the most gratifying of all procedures, especially to the patient.

Sympathetic nerve block is of great value, both from the diagnostic and therapeutic viewpoints.

J. C. M. C.


"In somewhat over a year since the Salerno landings, during the Italian and French campaigns, we have been privileged to operate upon 128 patients with abdominal wounds as a general surgical team of an auxiliary surgical group. During the early months of 1943 the senior author reviewed a series of 346 cases of the same type representing the early experience of the large group of surgeons of his organization. From these experiences, guided by the mature opinions of consultants in two theaters of war, and influenced constantly by close association with surgeons sharing the problems of forward surgery, we have evolved a plan of management. In those cases not exhibiting clinical shock mortality is less than 10 per cent, while in those in profound shock mortality is more than 60 per cent. Regardless of the shock state, operation is not begun without a cannula in a vein and blood or plasma running in. Resuscitation is continued throughout the operation. No patient died during anesthesia, nor has it been necessary to curtail operative procedures or to adopt compromise procedures in deference to the precarious condition of the patient. Ether has been selected as the anesthetic agent in every case. Since these patients have not received the preparation of abstinence from eating and morphinization usual to elective surgery, as thorough as possible lavage of the stomach has been done routinely. Additional preoperative morphine has rarely been necessary,
being usually given in amounts bordering on excess prior to admission. Atropine, 1/100 grain, has been given routinely intravenously shortly before induction. The endotracheal tube has been routinely introduced to aid in the maintenance of an adequate airway and to administer positive pressure anesthesia when necessary if the pleura were opened. The relaxation achieved has left nothing to be desired from the surgeon’s standpoint. Oxygen tension has been maintained at high levels throughout, an exceptionally important consideration in patients recovering from severely shocked states. Particular attention has been paid to the removal of accumulated intrabronchial secretions of blood and mucus at the close of the procedure.” 3 references.

J. C. M. C.


“Most thoracic surgeons in this area agree that the optimum operating conditions for intrathoracic disease, and also the least physiological upset to the patient, are afforded by the so-called ‘apneic technique’ of anesthesia, the patient’s lungs being intermittently inflated by gentle pressure on the breathing bag. However, this procedure necessitates the use of potent anesthetic agents, all of which, with the single exception of chloroform, are explosive, thus contraindicating the use of the cautery once the pleura is opened. . . .

When curare was first utilized as a relaxing agent in anesthesia for abdominal surgery it was claimed that its danger lay in its faculty of producing respiratory depression, which might even proceed to apnea if unduly large doses were used. As a result of this statement, we conceived the idea of using this property of curare for the production of apnea during intrathoracic operations. . . . To date this technique has been used on 11 patients undergoing intrathoracic operations in this hospital. . . . It has proved easy to produce apnea and control breathing, and no difficulty has been encountered in any case in persuading the patient to resume spontaneous respiration. The use of prostigmin for this purpose has not been found necessary. The patient’s general condition during the operation and postoperative course has been excellent in all cases. The only complications which could be even remotely attributed to curare are 3 instances of postoperative atelectasis. These may be attributed to the type of operation and the result of the medication. . . . A nitrous oxide and oxygen mixture is administered by means of a face mask. If any difficulty is encountered in producing anesthesia smoothly, enough sodium pentothal is injected intravenously to attain satisfactory anesthesia. . . . A quantity of curare calculated to be sufficient to stop spontaneous respiration is . . . injected intravenously. No particular precautions about speed of injection are taken. This first administration usually amounts to 150 to 200 milligrams of curare. Complete apnea or at least profound respiratory depression usually follows in from 30 seconds to 2 minutes. The patient’s lungs are then inflated by gentle intermittent pressure on the breathing bag. After approximately 5 minutes, when the maximum relaxation has been attained, the mask is removed and an orotracheal tube with an inflatable cuff is inserted under direct vision. . . . The patient is kept in apnea by means of small repeated doses of curare as long as the pleural cavity is open. . . . However, this method is still on trial; a much larger series of cases will be necessary before final judgment can be passed on the safety of curare for intrathoracic surgery.”

J. C. M. C.