by Lemmon, in that he uses a concentrated solution of procaine, and we use a dilute solution. The main advantage of the continuous technique for lumbar anaesthesia in our opinion is its safety factor.” 9 references.

J. C. M. C.


“Advances in pharmacology have been numerous and, at times, almost dramatic during the last three decades. Advances have not been limited to certain phases of pharmacology. Ether, by the open drop method, perhaps, is still the safest anesthetic in average hands but it has its disadvantages and, hence, the great activity on the part of pharmacologists to find better agents which are not explosive, nonirritating, nontoxic, etc. As a result of these investigations, we still have chloroform which is nonexplosive but extremely toxic, especially to the liver and capillaries; cyclopropane, which is nonirritating but which is highly explosive; nitrous oxide, which is relatively safe but asphyxiating; tribromethanol (or avertin), which produces sleep slowly and uniformly after rectal insertion but which may produce local irritation, liver damage or severe depression, since it is not as easily controlled as some other anesthetics. Even those recent synthetics introduced by Dr. John Krantz, cyproheptadine and cyproeth, are not entirely devoid of hazards. And, then, there are the various local anesthetics whose duration of action can be controlled with comparative ease and safety, depending on the area to be anesthetized regionally, topically, perineurally, intraspinaly, or caudally. And finally, the intravenous barbiturates were offered for speedy and convenient anesthesia. But all of the available anesthetics are inherently possessed of some disadvantages, as we so well know. Not only what is given, but how it is given, so frequently determines the outcome. Just as important, perhaps, is the patient to be anesthetized! (After all, he should be given some consideration, despite his inability, as a rule, to make an appropriate choice for himself.) This, the anesthetist does; this is his prerogative, since his is such an important contribution to good surgery. It is he who fits the anesthetic to the patient, not the patient to the anesthetic. Good surgeons appreciate good anesthesia and the anesthetist can pay in kind by appreciating the import of meticulous surgery and ‘surgical kindness’ to tissues. But today, despite numerous advances in the field of new anesthetic agents, we still await the introduction of the ideal anesthetic. That is a challenge to pharmacology!...

“Another pharmacologic contribution is that of 1-methyl-4-phenyl-piperidine-4-carboxylic acid, known as demerol. This was a timely introduction of an addition to the analgetic field because it came as a result of Pearl Harbor, in a way. Research on this drug had begun in this country in 1941, but its pace was soon accelerated because of the danger attending Japanese invasion of Asiatic countries which were sources of our morphine supply. About half a dozen laboratories and clinics set about feverishly studying this drug as a substitute for morphine. Approximately one year ago, it became available to the medical profession. It has the advantage of being capable of synthesis and this is not true of morphine; it is effective orally, is not constipating, and it is much less addictive than morphine. Although not quite as effective as morphine in analgetic potency, it is more effective than codeine.” 12 references.

J. C. M. C.