sion as to the use of intratracheal intubation.

Spinal analgesia has been used in certain cases. The dosage of 1 mg. of procaine per pound of body weight has been adequate in the author's experience. In children under 3 years of age, open drop ethyl ether anesthesia is best from the standpoint of potency and safety. The optimum psychic state is desirable. Induction of anesthesia should be uneventful and should not precipitate terrorizing memories. Some children, old enough to understand, may benefit by an explanation of the anesthetic process. Darkness, restraint and the smell of ether are three troublesome features of induction of anesthesia in children. The shield should not be placed over the eyes. Nitrous oxide, allowed to flow over the face without placing the mask tightly on the face, may bring about anesthetization without inducing fear. Attention to small details and proper premedication when necessary will minimize psychic trauma.

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The opinion given by an internist concerning the risk of anesthesia and a surgical procedure in a patient who has organic heart disease is based on the answers to several implied questions. "1. Will the anesthesia and surgical operation increase the demands upon the heart beyond the limits of the cardiac reserve and therefore precipitate congestive heart failure? 2. Does the heart require treatment before operation? 3. Is the prognosis of the heart condition so grave that operation should be avoided if possible or limited to an emergency or palliative procedure? 4. Is the heart condition such that it carries with it the liability to sudden death during anesthesia and surgery? 5. What bearing does the state of the heart have on the choice of the anesthetic? 6. What, if any, cardiovascular complications are to be anticipated during the operation and postoperative period?" The answers to these questions usually can be obtained from the clinical history and from the physical examination. As a rule, with few exceptions, patients with heart disease who have been able to carry on normal daily activities without experiencing symptoms of coronary or myocardial insufficiency can tolerate general anesthesia and surgery with no more risk than a normal person.

Careful questioning as to the occurrence of dyspnea or substernal pain on effort is more important than are cardiac findings on physical examination. An abnormal electrocardiogram in a patient who has been able to carry on normal activities usually does not indicate an increased risk from surgery and anesthesia. A period of preoperative treatment is advisable in pa-


Fear of cystoscopic examination persists in the minds of patients. This fear sometimes results in postponing the examination. Reassuring the patient, avoiding the use of the word cystoscopy, careful selection of instruments and skillful handling of instruments may help in overcoming fear. In the female introducing a small caliber cystoscope is, as a rule, no problem. In the male a local anesthetic should be injected into the urethra. General anesthesia is used for cystoscopy if catheterization is intolerable to the patient. 2 references.

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tients with organic heart disease who present signs and symptoms of myocardial failure. A surgical emergency will allow no delay and the risk of immediate operation must be accepted. It is best to administer ouabain or a suitable digitalis preparation by intravenous injection in those patients who have not been receiving digitalis and who have congestive failure. Rapid digitalization can be accomplished by oral administration of digitalis or digitoxin if the operation in patients who have mild or moderately severe congestive failures can be delayed for a few days. The ventricular rate, if auricular fibrillation is present, furnishes a helpful guide to the effect of digitalization. Treatment is continued until the rate is about 70 beats per minute. Strict limitation of the sodium chloride content of the diet should be made in the patients who have pulmonary congestion and peripheral edema. Mercurial diuretics may also be advisable.

Postoperative complications such as pulmonary embolism, atelectasis and abdominal distention are not well borne by the patients who have congestive failure regardless of the adequacy of the preoperative treatment. Digitalis should be administered to patients who do not have congestive failure but who have had dyspnea on moderate exertion or who have enlargement of the heart, evidence of valvular disease, auricular fibrillation, auricular flutter, frequent premature beats or electrocardiographic evidence of ventricular strain or coronary artery disease, as well as to patients who have enlargement of the heart due to hypertension. In elderly patients who do not have a diminished myocardial reserve, there is no evidence that preoperative use of digitalis is of any benefit. In the presence of serious heart disease the simplest operation which will accomplish the desired result is the procedure of choice. Certain heart conditions, even under normal conditions, are liable to result in sudden death of the patient. Recent myocardial infarction, angina pectoris, aortic stenosis, syphilitic aortic insufficiency and complete auriculoventricular block complicated by the Adams-Stokes syndrome should be detected before operation. Even mild anoxia or shock during anesthesia may cause sudden death. In the presence of these conditions it may be desirable to proceed as far as possible with local anesthesia. Spinal anesthesia causes a decrease in blood pressure and coronary flow. Reduced coronary flow may initiate a fatal arrhythmia or acute myocardial infarction. A skillfully administered anesthetic does not increase the work of the heart to an important degree.

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Older instruments and techniques made cystoscopic examination painful. By the use of newer instruments and perfection of techniques cystoscopy should be accepted by the patient as a routine examination. General, caudal or spinal anesthesia leaves the patient with the impression that he is submitting to a major procedure. Intravenous anesthesia with pentothal is safe and pleasant when it is administered by a trained anesthetist. Local anesthesia using 2 per cent intracaine is used in the male urethra. In the female, under ordinary circumstances, no local anesthesia is necessary. Lubricants in which the anesthetic is incorporated may interfere with proper visualization. Instillation of one ounce of a solution of nupercaine in oil will aid in relieving the distress of an extremely irritable bladder.

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