ether sequence is used for anesthesia. Intravenous infusion is started. Curare is given simultaneously with the skin incision, through the infusion tubing. Apnea, if it occurs, is controlled by intermittent manual pressure applied to the breathing bag. Additional doses of curare are given as circumstances indicate. Small doses are usually sufficient to maintain relaxation. One or two minutes before peritoneal closure, a dose of curare, only a little less than the original dose, is given. When the fascia is closed, 2 cc. of prostigmine, 1:2,000, is given intravenously. This amount of prostigmine was observed to have no effect on gastrointestinal suture lines.

Of 283 patients in whom curare was used 81 patients were classified as poor risks. The results were most gratifying. Two patients died on the operating table, both of shock, secondary to hemorrhage. No serious complication could be attributed to the curare. The use of curare should be limited to the anesthesiologist who has a thorough knowledge of endotracheal intubation, resuscitation, maintenance of general anesthesia with curare, and of clinical signs of carbon dioxide excess. 17 references.

F. A. M.


The art of anesthesia implies something that cannot be clearly seen, and demarcated, that cannot be exactly described and taught. It seems to imply a skill that comes of an inherent intuition, developed and conditioned by special experience. Surgical patients often are out of physiological balance. Restoration of this balance, either before or during surgery, is necessary. The Varco method of alimentary and parenteral feedings is an example of the good work being done along these lines. Accurate estimation of blood and fluid loss during operation and replacement helps to prevent the onset of shock. Development of practical ways for frequently determining blood concentration and specific gravity will make it possible to vary the speed and type of fluid replacement with greater accuracy than is now possible. Intratracheal intubation, measurement of the pressure in the patient’s lungs, removal of carbon dioxide from the anesthetic mixture with soda lime and control of temperature by cooling of the gases are some of the precision measures used by the anesthetist. Control of oxygen concentrations is possible, but there is now no way of determining the extent of carbon dioxide retention. A practical instrument for carbon dioxide and respiratory volume control is within reach. Electrocardiograms of each anesthetized patient may give warning and prevent occasional death on the table. More precision methods for more precisely controlled physiology are needed by the professional anesthetist. 4 references.

F. A. M.


A spectrophotometric method, based on the studies of Hellman and associates and of Brodie, was devised for the determination of pentothal. Five rabbits were used in the pharmacologic studies and three rabbits were used in the physiologic studies. Blood samples were also taken from two patients at Walter Reed General Hospital. The studies showed that “the plasma concentration quickly reaches a maximum level soon after intravenous adminis-