fluid therapy, inhalation therapy and the treatment of postanesthetic complications.

A brief summary of present day types of hospital-anesthesiologist relationships is pertinent:

1. Straight salary system.
   a. All anesthesia nurses.
   b. Department headed by physician anesthetist with nurses doing most of the cases. To pay the physician less than his net earnings would put the hospital in the position of practicing medicine with a profit derived from the exploitation of the physician.
   c. All physicians on salary. This plan is justified only when all other physicians are employed by the hospital.

2. Salary plus fees plan.
   a. A retainer is paid for teaching or supervision plus fees for private patients to whom any direct services are rendered.
   b. The physician collects his own fees and receives a percentage of fees collected by the hospital in return for supervision of the nurses work.

3. Fee plan.
   a. Group practice. This arrangement will provide continuous coverage and still maintain the proper doctor-patient relationship. The cost of equipment and supplies is borne by the hospital. The work and income are planned for a minimum of wasted time and to cover free cases.
   b. Independent fees. With the exception of a combination with other work, this type of arrangement does make efficient use of the anesthesiologist's time.

The specialty was neglected by the medical profession in the past and hospital administrators were placed in the position where they felt a responsibility to the institution to provide the service. However, the hospital that fails to recognize the status of anesthesia today, or who looks upon the anesthesia service for profit, is open to criticism or even legal action. Modern surgery is making demands on anesthesia that cannot safely and efficiently be met by anesthesia nurses. The hospital that clings to its control of the anesthesia department is doing medical science a real disservice. Surgeons are gradually coming to recognize this. Already hospitals have found it difficult to obtain or hold anesthesiologists on the salary basis. Surgical procedures that are safely performed with good anesthesia are becoming unsafe or impossible in places in which the hospital budget limits the number and quality of anesthesiologists. The scale of fees now being charged by many hospitals would provide adequate compensation to anesthesiologists once the hospital profit is eliminated.

M. F. P.


The anesthetic of choice depends on many factors. Proper preoperative care is many times more important than the use of any particular anesthetic agent. Preoperative medication is of major importance for all patients. Administration of adequate amounts of blood will reduce convalescent period.

In pediatric orthopedics, inhalation anesthesia is the most desirable. Open drop ether or vinethene is used if the time required is to be short. Oxygen is added by means of a catheter beneath the mask. There is a real need for a "children's machine" in every hospital.
From the age standpoint alone, there is little choice between spinal and inhalation anesthesia for adult patients undergoing an orthopedic operation on the lower extremities. If spinal anesthesia is not practical or desirable and the patient is on his abdomen, an endotracheal type of anesthesia is done. Nitrous oxide with never less than 20 per cent oxygen is used with pentothal. Pentothal sodium is used in inducing ether anesthesia. Barring explosion hazards, there is little to choose between the various agents if oxygen supply to the tissue, airway and replacement therapy are adequate.

For operations involving the administration of intocostrin an endotracheal tube is always used.

In the aged, because of law vital reserves, replacement and oxygen therapy are of the utmost importance.

For amputations in diabetic patients, there is no substitute for refrigeration anesthesia properly given.

Too much stress cannot be placed on supportive therapy before, during and after surgical intervention.

M. F. P.


Headache, which sometimes occurs after operation, is one of the commonest and most important complications of spinal anesthesia. In most studies, the frequency of post-spinal anesthetic headaches is given as 15 to 30 per cent. The headache usually occurs from the first to the fifth day after operation and it is stated to be more common in patients under forty years of age and in women. Two types of headache can be distinguished, a rare type in which the ache is of a splitting character and the other in which a band-like, oppressive ache around the head seems to be aggravated by movement and may be combined with vertigo. In the first type the picture is that of meningism. Meningism may be precipitated by infection, irritation by the anesthetic agent or by the needle. A search for an anesthetic which is less irritant than other agents has thus far been unsuccessful.

In a series of 362 cases of low spinal anesthesia headache occurred in 13 per cent. Etocain solution, 5 per cent, was used. The needles used varied in diameter from 0.7 to 1.0 mm. The main contributing factor was thought to be leakage of cerebrospinal fluid into the epidural space. The dural puncture openings were shown to be open for two weeks or longer in autopsy examinations. Leakage was minimized by using a special, fine needle with introducer (called the Antoni-Sise needle). The diameter of this needle is 0.5 mm. Using this needle and "heavy Decicaine" (pontocain-glucose with specific gravity 1.040) in 100 consecutive cases, no case of headache was reported. No special prophylaxis was used. Some of the patients walked from the operating table and others were out of bed on the day of operation. The technic would be especially useful for minor and simple operations where headache might be relatively of more consequence. 26 references.

F. A. M.