electively to relieve the usually innocuous pains of labor is unjustifiable. Since the recent advent of continuous caudal analgesia four women have lost their lives because of the procedure per se. There have been other 'close calls' reported. There must be other fatal or near fatal accidents which were not reported.

"The test of time will put continuous caudal analgesia in its approximate place in obstetrics and until this comes about we must hope that the minimum number of mothers will suffer harm." 13 references.

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"Local anaesthesia for bronchoscopy, using cocaine or newer substitutes... is probably employed in most clinics in this country. With the introduction of barbiturates of very rapid action it has become possible to spare the patient discomfort by superimposing light general anaesthesia on adequate local preparation. ... During the past five years we have evolved a technique which... has proved highly satisfactory in the last 600 consecutive cases. ... The average adult receives 'Omnopen' grain 1/3 and hyoscine gr. 1/150 an hour before operation; the dose is reduced for extremes of age or debility. It is essential that the hyoscine should take full effect, as shown by dryness of the mouth; if it does not do so, atropine sulphate gr. 1/100 intravenously may be given in addition. We are convinced that premedication helps to prevent spasm. ... The patient is placed on the operating table with his head on the bronchoscopic head-rest and given 10 per cent carbon dioxide in oxygen to breathe through a tube. ... As soon as hyperpnoea begins pentothal is injected. The average dose for an adult has been 8 c.em. of a 5 per cent solution injected during 30 seconds. Slower injection, particularly of a 2½ per cent solution, has been found unsatisfactory. Reduction in dose is made for age or poor general condition. The optimum dose is the smallest which will adequately relax the jaw muscles. When the mouth can be opened easily the injection is stopped and the glottis immediately exposed with a laryngoscope. During this preliminary laryngoscopy the anesthetist continues to offer the carbon dioxide-oxygen mixture through a Denis Browne's mouth-tube hooked into the corner of the mouth, thus maintaining stimulation of respiration. In nearly every case the larynx is found open and introduction of the bronchoscope is straightforward. In the few cases in which the larynx remains closed, on no account should any tentative movement of the bronchoscope be made; the bronchoscopist must wait until the cords open spontaneously—usually with a cough and without undue delay, if the technique has been carefully followed. After introduction of the bronchoscope oxygen is passed briskly through the side tube on the instrument, assisted by momentary positive pressure and by further carbon dioxide in the occasional case where spontaneous respiration is momentarily inadequate. A small additional dose of pentothal may be needed if the investigation takes long or the patient resistant. At the end of the operation the bronchoscope is slowly pulled up until the end lies just distal to the larynx.

"The carbon dioxide mixture is then delivered again until definite hyperpnoea is evident, when the bronchoscope is carefully withdrawn. This manoeuvre will usually prevent a withdrawal spasm. Should some degree of spasm develop however, 10 per cent carbon dioxide in oxygen can be given through a mask and airway under
pressure immediately on withdrawal of
the bronchoscope, and the vicious
circle of asphyxia is thus broken at its
inception. . . . The method is suitable
only for the experienced bronchoscop-
ist.” 8 references.

J. C. M. C.

DONELLY, J. F.: Analgesia in Obstet-
(June) 1944.

“The purpose of this paper is to dis-
cuss the drugs which are given during
childbirth; to relieve pain, to provide
the loss of sensation, or to render the
parturient amnesic for the pain. The
terms analgesia, anesthesia and am-
nesia are used to describe the preceding
effects. These terms are used inter-
changeably in this paper. . . . Mor-
phine and its related compounds have
excellent analgesic properties. . . . In
a recent article Mengert concluded that
the greatest fetal respiratory depres-
sion occurs during the third hour after
the administration of morphine and
that it should be avoided in premature
labors. He feels that, with careful
supervision and with adequate resusci-
tation facilities, it can be used safely.
We use morphine sulfate analgesia
frequently at the Hospital of the Uni-
versity of Pennsylvania and feel that it
is safe when Mengert’s warnings are
observed. Although heroin and dilu-
did produce less fetal depression they
are not widely used. . . . According
to Stander, barbituric acid derivatives
are the analgesic drugs most commonly
used in this country. They do not re-
lieve pain but make the patient am-
nesic. Of these derivatives, pentobar-
bital is used most widely. . . . Rectal
ether, chloral hydrate and paraldehyde
are given less frequently than mor-
phine or the barbiturates in labor.
They do not produce amnesia as satis-
factorily as do the barbiturates and
do not offer any greater safety. Ni-
trous oxide, ethylene, ether and chloro-
form are well-known inhalation anal-
gesic agents and will not be discussed.
Two newer analgesic agents, vinethene
and cyclopropane, are in the process of
evaluation. . . . The safety of spinal
analgesia has been debated since Cos-
grove reported its successful use in
1934 for Caesarean section. . . . On
account of the potential dangers as-
associated with spinal analgesia it can be
used only where proper facilities are
available. . . . Although some authors
think that intravenous analgesia is safe,
it is not generally believed to be safe
enough for use in obstetrics. Kroger
and DeLee reported upon the use of
hypnosis to produce analgesia during
labor and delivery. They confirmed
the observations of others who have
used it with success. The low risk to
the mother and baby warrant further
investigation of this method. No com-
ments need be made on the use of pu-
dendal field block. It is a simple, in-
expensive and satisfactory method of
relieving perineal pain for delivery.

. . .

“The use of Demerol and the in-
roduction of continuous caudal anal-
gesia are the two outstanding new de-
velopments in obstetrical analgesia.
. . . In spite of recent innovations in
the field of obstetrical analgesia, the
ideal is yet to be found.” 40 referen-
ces.

J. C. M. C.

MACINTOSH, R. R.: Publication of An-
aesthetic Misadventures. Brit. M.
J. 1: 633–634 (May 6) 1944.

“Dr. John Elam has campaigned
persistently for safer anaesthesia. . . .
The pages of the medical journals testi-
yfy that anaesthetists, like other mor-
tals, rush into print more readily with
their successes than with their tragedies
—yet it is from the latter that more can
be learnt. Anaesthetic misadventures
are not rare. The accidents I have
heard of recently varied considerably
in character. One can well imagine
the mortification of giving pentothal