group 1, the patients were awake on an average of 27 minutes after operation while in group 2 it was 45 minutes before they responded. A shorter period of recovery is of great advantage, of course, in rendering the patient more co-operative and also in allowing a more rapid return to normal of muscle tone and other physiological processes. However, one of the most striking differences in the two series is in the mortality rate. In group 2, it was 12 per cent. while in group 1, it was only 5 per cent. Whereas we realize that the other differences in the treatment of these two groups of patients are significant, we feel that the combination of intravenous anesthesia with spinal anesthesia is of paramount importance in producing these favorable results.” 15 references.

J. C. M. C.


“...The short acting barbiturate, pentothal sodium, because of its ease of intravenous administration and the smooth and quick induction of anesthesia with rapid recovery, seems particularly applicable to obstetrical operations. . . . We employed] a 2.5 per cent solution of pentothal sodium intravenously for anesthesia. . . . The maximum dose necessary was 1500 mg., the minimum 175 mg., and the average was 625 mg. During the first stage of labor, analgesia was obtained with a combination of morphine, hyoscine, sodium amytal, and rectal ether. . . . When the cervix was judged to be fully dilated, preparation was made for delivery; pentothal sodium was given intravenously. A perineal nerve block was performed with 1 per cent procaine, and as the head was delivered, the intravenous injection was discontinued. . . . In this series of 100 cases, there were no maternal deaths, nor any complication due to the anesthetic. . . . Pentothal sodium has been very satisfactory in our hands and is a distinct adjunct to the obstetrician’s method of relieving pain.” 9 references.

J. C. M. C.


...The original methods of ice anesthesia advocated the use of rubber sheets to hold the ice. The writer and Dr. Jules D. Gordon of New York City, found that method faulty in many ways. . . . The technic used by the writer is as follows: Apply three ice caps to tourniquet area for 15 minutes and hold in place with a piece of muslin. Keep limb elevated during this period. A minute before this time is up apply an Esmarch rubber bandage firmly and slowly from above the area of inflammation to the tourniquet site. At the expiration of 15 minutes remove the ice caps and use the piece of muslin to protect the skin and then apply the tourniquet. Remove the rubber bandage. Then the limb is ready for the application of ice. The bottom of the ice container has previously been prepared with a layer of finely chopped ice on an incline distal to proximal. . . . The limb is placed in the ice container and covered with finely chopped ice to 2 inches above the tourniquet. The head of the bed is ‘gated’ up and the bed placed on small blocks at the head to facilitate drainage. . . . The limb is kept in the ice container for 2 hours, being examined at intervals and ice being added if needed. After 2 hours the patient is taken to the operating room. The limb is removed from the ice, dried off, and is ready for amputation. The operating crew should be ready to go into action as soon as the patient is