rent must be so weak that it does not produce a contraction even of the normal muscles of the eye. Resection and resection of the muscles should not be resorted to for a period of two years if the muscle has failed to reestablish itself. . . . Two cases are presented." 10 references.

J. C. M. C.


"Pain sometimes remains as the only symptom to interfere with an otherwise satisfactory result following an injury. . . . Weir Mitchell first described and named a condition causalgia which he observed in soldiers who had been injured during the Civil War. Causalgia literally means a burning pain and the type of pain he described from incomplete severance or injury of a nerve was very intense. The soldiers had a severe burning pain in the distribution of the nerve affected. The area was hyperesthetic. There were paresthesias and the subject protected himself from the slightest stimuli. Heat, cold and even wind would cause an exacerbation of the pain to such an extent that they attempted to avoid them. Pains of a milder character which may not be regarded as typical causalgia occur more frequently and may persist late in convalescence from injuries. Leriche was the first to realize the practical importance of the sympathetic nervous system in arresting pain of such character. . . . Four instances are given in the form of case reports where repeated sympathetic nerve blocks with novocain in conjunction with physiotherapy resulted in recovery of the patient and rehabilitation of an extremity. In two instances the results otherwise had been regarded as permanent and total disability." 2 references.

J. C. M. C.


"It is impossible to catalogue separately the indications and contraindications in spinal anaesthesia, for a deterring factor in one case might under slightly altered circumstances have no influence in another case. . . . We all have had patients who presented a strong antipathy to spinal block. Personally I have refrained from fore-going the issue. . . . Age is no barrier to this technique. . . . The young, robust and muscular individual is often difficult to control with inhalation anaesthesia but is an excellent subject for spinal block. . . . It is generally conceded by most authorities that spinal anaesthesia should be confined to operations below the diaphragm, that its greatest field of usefulness is in abdominal surgery, and that it should not be used for minor operations, which can adequately be performed under field block or some gaseous anaesthetic agent. I wish to add my endorsement to this last view. . . . In abdominal surgery and particularly in upper abdominal lesions spinal anaesthesia is the undisputed anaesthetic of choice. . . . Advanced cardio-vascular disease is a definite contraindication to high spinal anaesthesia. . . . Patients with an extremely low blood pressure should also receive every consideration before deciding to employ spinal block. . . .

"Patients with decreased blood volume such as occurs in shock or dehydration from prolonged vomiting are to be considered unsuitable. Disease of the central nervous system such as intracranial tumours, cerebral haemorrhage, tumours of the spinal cord and meningitis are definite contraindications in subarachnoid block. A posi-
tive history of syphilis should make one hesitant to employ spinal. . . . Carci-
noma of the prostate with its possible rapid metastasis following operation
may produce a paralysis that will be attributed to the lumbar puncture.
Pernicious anaemia with its concomi-
tant neurological changes presents a
similar problem. A preanaesthetic
explanation to the relative of the possible
sequelae in these cases is advisable.
Septicaemia is a deterring factor to
the use of spinal anaesthesia. . . .
Likewise, lumbar puncture should not
be attempted in the presence of super-
ficial or deep seated infection at or
near the site of injection. In patients
with respiratory complications, sub-
arachnoid block is especially indicated.
. . . Theoretically, spinal anaesthesia
is the anaesthetic of choice for diabetic
patients but the frequent coincidence
of cardio-vascular degeneration with
this disease necessitates consideration
of the additional risk. Organic changes
in renal function are little affected by
spinal anaesthesia. Hence it is the an-
aesthetic par excellence in kidney dis-
ases. The advantages of spinal anaes-
thesia to the new-born, in Caesarean
section, have been set forth by Heard.
. . . We personally prefer cyclopropane
for this operation. . . .

"In conclusion I would like to em-
phasize the necessity first, that spinal
anaesthesia be entrusted only to those
who through training and practical ex-
perience have made themselves pro-
ficient in its use, and second, that care-
ful and constant observation of the
anaesthetized patient be kept through-
out the entire operation. Upon care-
ful consideration of the effects of spinal
anaesthesia on the disease present, to-
gether with the urgency of relaxation
to facilitate surgical manipulation, and
upon the judgment and ability of the
anaesthetist, must rest the decision
whether spinal anaesthesia is or is not
indicated." 8 references.

J. C. M. C.

ABNOTT, G. M., AND YOUNG, W. F.: Postoperative Administration of
Fluids to Children. Lancet 1: 523–
526 (May 2) 1942.

"Children who are suffering from
acute abdominal diseases often become
dehydrated. They take less by mouth,
they lose more by the skin and lungs,
vomiting may add to their distress and
persistent vomiting may lead to a seri-
ous loss of salt as well as of water. The
commonest causes of vomiting of this
type in children are hypertrophic pyl-
oric stenosis, paralytic ileus and in-
tussusception. In the last two, large
volumes of the gastro-intestinal juices
may accumulate in the distended coils
of bowel and so increase the degree of
dehydration. Treatment may also in-
crease dehydration if the stomach is
often washed out, or if suction drainage
is instituted or an enterostomy per-
formed. Haemorrhage into the bowel
in intussusception may contribute to
the dehydration, but it requires treat-
ment by blood-transfusion if the loss
of blood has been severe. . . . It was
found that, in children, degrees of de-
hydation ranging from mild to mod-
erate and severe were relieved by vol-
umes of fluid representing 3–6% of
their body-weight. As the tissues ab-
sorbed the fluid the patients assumed
a more normal appearance, the sunken
features filled out, the skin regained
its elasticity, the mucous membranes
became moist, and larger volumes of
less concentrated urine were passed.
Lashmet and Newburgh (1932) have
shown that the normal kidney can con-
centrate urine to a specific gravity of
1032, and that even with this concen-
tration an adult must secrete 500 c. em.
each day to eliminate the waste prod-
ucts of the body. Accordingly, the
restoration of normal volumes, coupled
with a fall in the specific gravity of the
urine, were accepted by us as proof
that adequate amounts of fluid were
being given. Confirmation was ob-