... In children a general anesthetic is always used. In no case have I seen any complications develop as a result of ether. I have seen cases where the lack of anesthesia caused the operator to traumatize his patient resulting in exhaustion and greater shock. ... Contraindications to general anesthesia are cyanosis of marked degree and lung abscess or stricture of the esophagus when repeated treatments are necessary. Local anesthesia in adults is quite satisfactory. The procedure is usually surprisingly comfortable for the patient. Plenty of preliminary sedation is helpful and in certain cases intravenous morphine is very satisfactory. Local applications of cocaine solution to the gums, pharynx, and larynx as well as instillation into the trachea is a routine. This is best done with the patient in the upright position. General anesthesia may be necessary and intravenous sodium pentothal is satisfactory, particularly if preliminary cocainization has been employed."

J. C. M. C.

SMITH, ANGUS: Convulsions under Anaesthesia; Treated by Change of Posture. Lancet 1: 52 (Jan. 8) 1944.

"Many cases of convulsions under anaesthesia have been reported, and much has been written about the condition. It is now generally accepted that toxicity, pyrexia and youth are predisposing factors. ... In ... 2 cases ... the predisposing factors were present. Treatment merely by sitting the patient up was successful. ... In the case of any young patient who has an acute toxemia and pyrexia, it is probably wise to avoid the closed-circuit technique and to apply a slight foot-down tilt to the table. When the convulsions have started, mere raising of the head may not be sufficient, and it seems advisable to sit the patient up completely."

J. C. M. C.


"I have the privilege of presenting at this time a study made in 1942 of maternal deaths following instrumental delivery. ... The Division of Vital Statistics of the Philadelphia Department of Public Health informs us that 43,044 babies were delivered in this city in 1942 and that 39,162 were delivered in hospitals. In response to an annual survey made by the Maternal Welfare Committee by means of a hospital questionnaire, we were informed that 24,130 were delivered spontaneously and 15,022 were delivered operatively. ... There were 98 mothers who died from childbirth. ... Of the 98 deaths, 15 occurred after an instrumental delivery. ... The anesthetic or analgesic administered to these 15 patients [was] ... nitrous oxide and ether in four, gas-ether in three, nitrous oxide and oxygen in two, rectal analgesia and ether in one, cyclopropane in one, ether in two, and no anesthetic in two instances. ... I believe ... that operative deliveries are not without danger. The administration of anesthesia and the increased amount of manipulation always have a tendency to increase this danger; therefore, one should always be prepared to meet an emergency." 3 references.

J. C. M. C.


The authors first present a program for the management of shock as it may be encountered universally; first, institution of reparative measures early after the trauma has been sustained,
preferably early in the so-called “latent period” of four to six hours, placing of the patient in the horizontal rather than the Trendelenburg position, except for the use of Trendelenburg position for the primary shock occurring immediately after trauma; exposure of the patient to room temperatures rather than covering him with heaters or blankets, thereby helping to combat the ill effects of anoxia by lowering of the demands of the body for oxygen; adequate sedation, but not enough to cause any respiratory depression; the use of 100 per cent oxygen, preferably with positive-pressure apparatus; fluid replacement, consisting of rational doses of plasma and crystalloid solutions; and judicious use of the whole extract of adrenal cortical hormone. It is contended that positive-pressure inhalation is more satisfactory for the relief of pulmonary edema than are hypertonic solutions of albumin. Certain “don’ts” of shock therapy are advanced: refraining from the use of digitalis, epinephrine, caffeine or strychnine; withholding of chemotherapeutic agents until the renal output is such that the excretory products can be handled by the kidneys.

Most of the deaths following inhalational gas poisoning are due to pulmonary edema and cardiovascular failure. The treatment “should consist of two main parts, the first directed toward continuous bronchial relaxation, and the second toward the application of positive pressure with mixtures of oxygen or helium and oxygen to the inner surface of the lung.” Relief of bronchospasm may be obtained by rectal instillation of aminophyllin two or three times daily, continuing the treatment for one to three weeks, or by the use of nebulized sprays of neosynephrine or epinephrine directed into the oronasal passages. “Proper humidification of the room air and the inhaled gases should be observed.” Iodides may be used in the later stages to relieve the dry, nonproductive cough.

Positive-pressure inhalation therapy is an excellent means of combating pulmonary edema, and may cause it to disappear and remain absent while pressure is applied or until the cause has been removed. If the dyspnea is caused mainly by anoxia, the gas therapy should consist of oxygen in concentrations of 95 per cent or more; if it be due largely to respiratory obstruction, the gas therapy should consist of helium-oxygen mixtures, e.g. 80 per cent helium and 20 per cent oxygen. Positive pressure can be applied by means of the Barach mask or helium-oxygen rebreathing hood apparatus, with a pressure of 2 to 5 cm. of water usually sufficient. The authors do not advocate tracheotomy for tracheal edema unless provision is made for application of positive pressure through the cannula.

C. S. H.


Dr. Mahorner states: “. . . it is surprising what may happen with regard to certain pains when the sympathetic nerves are interrupted.” Pain may be the predominant symptom in various types of vascular disease. It has not been determined whether “pain or vasospasm is antecedent or whether they are concomitant and not cause and effect.” The vascular changes may be acute or chronic, with vasodilatation or vasoconstriction, or both; and they may be accompanied by other objective changes, such as edema, coldness and clamminess of an extremity, limitation of motion of a joint, paresis of a nerve, or pain in the distribution of a nerve, as in posttraumatic states.

Patients with such posttraumatic