ABSTRACTS

Editorial Comment: A fixed style of presentation for this department of ANESTHESIOLOGY has purposely not been defined. It is the wish of the Editorial Board to provide our readers with the type of abstract they desire. Correspondence is invited offering suggestions in regard to the length of abstracts, character of them, and source of them. The Board will appreciate the cooperation of the membership of the Society in submitting abstracts of outstanding articles to be considered for publication.

TUOHY, E. B.: *Anesthesia in Abdominal Surgery.* J. Indiana M. A. **41**: 398–400 (Apr.) 1948.

"An accurate evaluation of the patient's physical status and emotional stability is of primary importance when considering the agent and method of anesthesia for abdominal surgery. . . . I believe there is little doubt that the greatest percentage of abdominal laparotomies are performed with the patient under general anesthesia, for which purpose ether is probably the main anesthetic agent. Nitrous oxide or perhaps ethylene is used as the induction agent. The almost universal safety of ether for children and adults makes it very popular. Cyclopropane, because it is pleasant to inhale, nonirritating and rapid in its action, is quite a favorite anesthetic agent. Curare has enhanced the utility of cyclopropane because it will produce the necessary muscular relaxation without the pre-requisite of deep anesthesia. . . . Whether the agent be ether, nitrous oxide, oxygen and ether, cyclopropane, or chloroform, an adequate airway must be provided. . . . For the most part we reserve the use of regional anesthesia, local infiltration, field block or intercostal block for debilitated patients requiring surgery. . . . Both inhalation and spinal anesthesia have advantages in abdominal surgery. Individual evaluation must be made. . . . The careful intravenous use of fluids, such as dextrose and saline solutions, and blood transfusion are important. . . . The anesthesiologist should be prepared to perform two endoscopic procedures when required; namely, suction bronchoscopy and the introduction of drainage tubes into the stomach. . . . Various agents, such as pentothal sodium, curare and cyclopropane, can be employed in combination with other anesthetic agents and procedures." 1 reference.

J. C. M. C.

WARDROP, DOROTHEA M.: *A Comparative Study of Continuous Spinal and Cyclopropane with Curare.* Canad. M. A. J. **58**: 343–348 (Apr.) 1948.

"In 1939 Lemmon of Philadelphia began his work with a new technique for producing spinal analgesia which he called continuous . . . spinal anesthesia. I have personally administered this type of anaesthesia to 110 cases slated for major abdominal procedures. These were all selected cases considered to be poor surgical risks. . . . In this series there were no deaths in the operating room and no deaths in the hospital attributable to the anaesthetic. . . . From the surgeon's point of view then this type of anaesthesia seemed fairly acceptable. Relaxation was satisfactory and there was no time limit to the anaesthetic. . . . In 1942, the work of Griffith and Johnson was made public and subsequent glowing reports

of other anaesthetists using the new purified form of curare (Squibb-Intocostrin) as an adjunct to anaesthesia stimulated us to venture into this new technique. . . . From March 1945 to January 1947 this anaesthetic combination was personally administered to over 400 consecutive cases undergoing major abdominal procedures with apparently great success. Of the 400 patients, 33 were considered to be excellent operative risks, 189 fairly good, 162 only fair, 18 poor and 1 bad. The surgeons were particularly pleased with the results. . . . It would appear that both types of anaesthesia, continuous spinal and cyclopropane with curare, are suitable for major abdominal surgery. Both can be made to provide satisfactory abdominal muscle relaxation for long periods of time. Continuous spinal anaesthesia requires special apparatus and about twice as much time to prepare the patient for the surgeon. Under the spinal also, the patient's general condition did not seem to be quite as satisfactory as under the general anaesthetic. . . . The chief advantages of the cyclopropane curare method are the ease of administration, the profound relaxation without evidence of shock and rapid recovery." 8 references.

J. C. M. C.

ANDROS, G. J.; DIECKMANN, W. J.; OUDA, P.; PRIDDLE, H. D.; SMITTER, R. C., AND BRAYAN, W. M., JR.: *Spinal (Saddle Block) Anesthesia in Obstetrics.* Am. J. Obst. & Gynec. **55**: 806–820 (May) 1948.

"Analgesia and anesthesia are important medical treatments to anyone who is in pain. . . . The doctor must always remember that any interference with the normal course of labor—hypnotics, oxytocics, anesthetics—increases the hazards for mother and baby. . . . This is a study of 719 cases of modified saddle block anesthesia carried out at the Chicago Lying-in Hospital between January 5, 1947, and April 24, 1947. These cases represent 58 per cent of all patients delivered during this period. . . . The technique of anesthesia was demonstrated to us by Parmley, and was used throughout the study with minor modifications only in so far as drugs other than Nupercaine were involved. The majority of the injections were carried out with the patient in her labor bed, under the mattress of which had been inserted board supports to prevent sagging. The patient was placed in a sitting position over the side of the bed, bending forward and supported by an assistant. . . . Spinal puncture was made at the level of the fourth lumbar interspace. In case of difficulty at this point the third space was utilized. A short-beveled 22-gauge needle three inches in length was used in the majority of cases. When a free flow of clear spinal fluid was obtained, a Luer Lok syringe containing the properly prepared solution . . . was attached to the spinal needle, aspiration of 0.1 c.c. spinal fluid carried out, and the solution injected rapidly. At the end of ten seconds the needle was removed, and at the end of thirty seconds the patient was placed flat on her back with a pillow under the head to keep the neck sharply flexed. The procedure was timed to be carried out in its entirety between contractions of the uterus, to prevent any abnormally high level or aberration of anesthesia which might result from spinal fluid turbulence coincident with contraction. . . . All but seven of the anesthetics were completed with four drugs: . . . Buffered nupercaine (formerly percaine) in 1:200 solution, the drug used by Parmley and Adriani, was administered to 404 patients in dosage of 2.5 mg. Premixed unbuffered nupercaine (2.5 mg./c.c. in five per cent glucose) was tried in 109 instances. These two