and two years later, he makes his first reference to the use of cold as '. . . a local means for producing insensibility during surgical operations.' . . . In September of the same year Arnott opened what was to prove a lifelong campaign against the dangers of inhalation anaesthesia. . . .

"In February, 1854 . . . he wrote a tract which was published by John Churchill, with the title, 'The Question Considered' and the rather ponderous sub-title: 'Is it justifiable to administer Chloroform in Surgical Operations after its having already proved suddenly fatal in upwards of fifty cases when pain can be safely prevented, without loss of consciousness, by momentary Benumbing Cold?' The following month he defended his title to be the instigator of the use of 'frigorific mixtures' against the claim of some of his Parisian colleagues in a paper. . . . In 1857 he produced a long article 'On Congelation as an Anaesthetic.' . . . 1867 saw Arnott's last effort for his method. In the Medical Times and Gazette of March 30th he wrote "On the Invention of Local Anaesthesia by Refrigeration.' . . . Arnott's work has been almost entirely forgotten except as a reference in a recent book. The revival of interest in refrigeration has provided an excuse to bring it to light again."

J. C. M. C.

KIRCHHOF, A. C., AND BOALS, D. C.: *Anesthesia for Total Laryngectomy.* West. J. Surg. Obst. & Gynec. **56**: 590–591 (Nov.) 1948.

"Total laryngectomy has become the treatment of choice in an increasingly large number of patients with cancer of the larynx. . . . The procedure we have found most effective is to introduce an oral endotracheal tube with inflatable cuff under direct vision for the early part of the operation. After the surgeons have dissected the larynx and upper trachea free, the endotracheal tube is pulled back as far as the vocal cords and the trachea sectioned transversely. A short piece of sterile endotracheal tubing with a bevelled tip, and equipped with an inflatable cuff is inserted by the surgeon into the open end of the trachea and the cuff inflated. The short tube (three to four inches in length) is fitted with a standard 90 degree elbow which has a suction hole covered by a sleeve of rubber tubing. This in turn is connected to a long rubber tube. This assembly (short tube and cuff, elbow and long tube) is sterilized in alcohol or other reliable antiseptic solution before surgery, and put in the surgical pack. . . . After insertion of the tube and inflation of the cuff by the surgeon, the longer tube is passed through the drapes to the anesthetist who reestablishes the closed system with the anesthesia machine."

J. C. M. C.

GORDH, T.: *Xylocain—A New Local Analgesic.* Anaesthesia **4**: 4–9 (Jan.) 1949.

"In 1943 Lofgren and Lundqvist, at the Organic Chemistry Institute of Stockholm University, produced a series of new compounds which in chemical composition were basic anilides different in structure from the local analgesics of the cocaine procaine group. One of these compounds w-diethylamino- 2.6-dimethylacetanilide, which was called xylocain, showed promise. . . . At the surgical clinic of Karolinska Hospital the new preparation has been on trial since 1944. . . . Clinical investigation began with wheal tests. . . . No local reaction was observed in this series. If adrenaline was added in concentration of 1 : 100,000, a considerably longer duration of analgesia was obtained. Whereas a 1 percent procaine solution with adrenaline has a duration of about 60–90