

4500 cc. The blood loss in neurosurgical treatment is highest for intracranial procedures. During operations on the spinal column or spinal cord 500 cc. of whole blood should be administered. . . . The time required to perform an operation is exceedingly important. The effect of blood loss depends on the relationship of the amount lost to the total blood volume, the rapidity of loss and the preoperative status of the patient. . . . Knowledge of blood loss obviates the possibility of insufficient or excessive replacement therapy."

J. C. M. C.

LEWIS, C. B.: *Endotracheal Intubation Under Thiopentone. An Analysis of 200 Cases.* *Anesthesia* 3: 113-115 (July) 1948.

"In order to investigate (a) the incidence of spasm; (b) the effectiveness of the adjuncts (cocainisation, curare, etc.) and (c) the percentage of successes, endotracheal intubation has been attempted under thiopentone alone in 200 cases, in 100 through the nose by the blind method, and in 100 by direct vision through the mouth. . . . From our experience we believe that aids to intubation such as deep inhalation anesthesia, carbon dioxide, cocainisation and curare are unnecessary. . . . In our series of cases, severe intractable glottic spasm never occurred. Minor degrees of spasm were invariably quickly relieved by supporting the jaw; no further attempt at intubation being made until the spasm had ceased."

J. C. M. C.

LYONS, SYDNEY S.: *Anesthesia in Thoracic Surgery with Reference to Surgery of the Esophagus.* New York: State J. Med. 48: 1943-1946 (Sept. 1) 1948.

"One of the most important features of thoracic physiology is that all of its organs function under a pressure less

than that of atmospheric air. This negative pressure is immediately altered when the pleural cavity is opened to atmospheric level. . . . Disturbances in the normal negative intrapleural pressure by creation of an open pneumothorax is no longer a serious problem since the introduction of modern anesthetic technics. . . . Reviewing some 224 consecutive cases of thoracic operations for cancer of the esophagus performed at the Mount Sinai Hospital, some interesting observations have been made. . . . The earliest respiratory phenomenon occurs when the surgeon enters the pleural cavity. Anesthesiologists have frequently failed to make adequate provision to safeguard against the sudden and rapid collapse of the lung on the corresponding side. . . . Maintenance of positive pressure on the rebreathing bag permits a gradual deflation of the lung to partial or semicollapsed levels and militates against . . . sudden and rapid collapse. At no time during the entire operative procedure should the lung be permitted to collapse completely. . . .

"There is no need to stress the fact that one of the great advances in anesthesiology has been the development of intratracheal intubation methods. . . . Occasionally, the surgeon may accidentally open the opposite pleural cavity while freeing a particularly adherent tumor. The alert anesthesiologist can recognize this accident by an immediate diminution in the tidal exchange, increased respiratory rate, tachycardia, fall in blood pressure, and moderate gray cyanosis. Unless swift and adequate closure of the opening is made, death will result in the majority of cases. In our series, this accident occurred 12 times. Nine of these succumbed in from a few hours to the third day postoperatively, with complications definitely referable to the respiratory system. . . . Upon completion of the operation an effort is