made to close the chest, to make it 'air-tight.' In the main, these attempts include some form of pressure or suction method. . . . Despite the most painstaking closure and attempts to remove all trapped air, irrespective of the method utilized, the negative pressure obtained immediately postoperatively is temporary. In our series of cases, 42 per cent showed clinical evidence of air in the chest on the operated side. . . . For the past few months, we have instituted an anesthetic-surgical technic for obtaining an air-tight closure of the chest with gratifying results. . . . An attempt is made to replenish the inspired atmosphere with nitrogen or helium at the conclusion of the operation. . . .

"Slight overexpansion of the lungs and its continued maintenance at that level is imperative, i.e., until the wound is completely closed, dressing and adhesive or bandages applied, and underwater drainage established. . . . In the last 23 cases where this closure technic has been employed, the lungs have remained completely inflated during the entire postoperative period. Clinically, these patients have shown no signs of respiratory embarrassment; aspiration of the chest has not been necessary, and we have had no respiratory complications. . . . With the exception of phenomena directly referable to blood loss, surgical trauma, and the preoperative physical status of the patient, circulatory accidents are rarely encountered. . . . Stimulation of the vagus nerve may be responsible for reflex effects on respiration and circulation which may appear before surgery is attempted. It has occasionally been precipitated by preliminary tracheal intubation. . . . Although fatalities from vagal stimulation have been known to occur, they are fortunately rare, but the less serious reactions interfere with the conduct of the anesthesia and superimpose an added burden on the patient. These reflexes may be depressed by the preoperative use of parasympathetic inhibitor drugs such as atropine and scopolamine. More recently, however, the local application of intravenous injection of procaine solutions has largely eliminated these hazards. . . . In this series of cases we have at one time or another employed every anesthetic agent and technic at our disposal with the exception of local infiltration, spinal anesthesia, and intravenous barbiturates. . . . We now routinely use for induction nitrous oxide, ethylene, or cyclopropane, if there are no contraindications to the use of the latter agent, and then complement the inducing agent with ether. . . .

"Since the majority of these patients have a marked reduction in their vital capacity, we purposely under-premedicate our patients so that the threshold of the respiratory center will not be too greatly elevated."

J. C. M. C.

SMITH, G. F. R.: *The Teaching of Anaesthesia.* Anaesthesia 3: 110–112 (July) 1948.

"All that a dental surgeon should know could easily be given in three lectures and this would obviate padding with details of those anaesthetics no dentist would consider using. . . . A nurse should certainly know something of the properties of the agents in common use, and such theory can only be imparted in lectures. The practical side she can pick up in the surgical wards and in the theatre, and here the sister will be largely responsible for teaching. Gas and air instruction is already included in the C.N.B. course. . . . At Universities one question to be settled is whether the teaching of physics, anatomy and physiology should be in the hands of the professors of those subjects or left to the anaesthetic specialist."

J. C. M. C.