over the obstetric maneuver. (*Dinnick, O. P., and others: Discussion on Anaesthesia for Obstetrics; Evaluation of General and Regional Methods, Proc. Roy. Soc. Med. 50: 547 (Aug.) 1957.*)

SPINAL In a series of 5,212 normal deliveries low spinal anesthesia was administered. This, along with intravenous methylergonovine and routine exploration of the uterus, contributed to minimal blood loss and decreased puerperal morbidity. (*Cartwright, E. W.: Management of Third Stage of Labor, Obst. & Gynec. 10: 518 (Nov.) 1957.*)

PUDENDAL BLOCK Suppression of nervous impulses proceeding along pudendal nerves adversely affects the course of labour. Pudendal anaesthesia is therefore contraindicated in cases of uterine inertia. (*Gryaznova, I. M.: Painless Childbirth with Use of Local Anaesthesia, in Light of Reflex Nature of Labour, Aakh. Ginek. 5: 19, 1956.*)

BRONCHOSCOPY The average adult patient is given premedication and induction is accomplished with intravenous thiamylal, 150 to 200 mg., followed rapidly by succinylcholine, 40 mg. As soon as relaxation develops a no. 4 Magill Portex endotracheal tube is passed through the larynx. The tube is then connected to an anesthesia machine and nitrous oxide-oxygen (2:1) administered at a rate sufficient to assure adequate exchange and washout. Respiration is assisted as indicated. The bronchoscope is passed so as to follow the endotracheal tube as a guide which it passes either alongside of or behind into the larynx and trachea. Bronchoscopy is completed with the endotracheal tube in place and gases being delivered through it. Certain modifications in this technique are used in very old and very young patients, but the principle of maintaining respiratory control remains the crux of the method. (*Reitman, J. S.: General Orotracheal Anesthesia for Bronchoscopy, J. A. M. A. 165: 943 (Oct. 26) 1957.*)

TETANUS A series of 558 cases of tetanus were treated during a 14-year period at the Charity Hospital in New Orleans, Louisiana. A variety of therapeutic measures were employed in the last seven years consisting, in addition to other methods, of antibiotics, tracheotomy, muscle relaxants and gastrostomy. The Department of Anesthesia provided sedation and muscle relaxation for patients. Initially, chlorobutanol and magnesium sulphate were used, then morphine, bromides, amobarbital, chloral hydrate, phenobarbital and tribromoethanol. At the present time, sedative and anticonvulsive therapy consists of mephenesin, barbiturates, and chlorpromazine. (*Creech, O., Glover, A., and Ochsner, A.: Tetanus: Evaluation of Treatment at Charity Hospital, New Orleans, Louisiana, Ann. Surg. 146: 369 (Sept.) 1957.*)

ANESTHESIA HISTORY The oldest anesthesia society in the world is the London Society of Anaesthetists, founded in 1893. The second oldest, and the forerunner of our present American Society of Anesthesiologists, was the Long Island Society of Anesthetists, founded in 1905. This latter officially changed its name to the New York Society of Anesthetists in 1911 and to the American Society of Anesthetists in 1936. Initial efforts toward formation of a section on anesthesia of the American Medical Association were made in 1912, but it was not until 1940, and after great effort had been exerted by many determined anesthesiologists, that this goal was attained. The American Board of Anesthesiology was established as a separate major board in 1941, having been incorporated first in 1938 as an Affiliate Board to the American Board of Surgery. With these major achievements our progress must not flag. The threat of complacency is real; our very freedom—personal, professional, civic—can be lost through complacency. (*Smith, S. M.: Story of Section on Anesthesiology of American Medical Association, J. A. M. A. 165: 939 (Oct. 26) 1957.*)

SURGICAL CARE OF INFANTS It has been said that, "The adult may safely be treated as a child but the converse can lead to disaster." The isolette provides regulated heat, humidity, and oxygen to the tiny infant. Intermittent gastric suc-