been made to open the jaws immediately in case of respiratory difficulty or vomiting. A very satisfactory anesthesia may be obtained by a deep block of the second and third divisions of the fifth nerve with 2 per cent procain hydrochloride. In many cases it is possible to wire the teeth with no anesthesia other than a preliminary hypodermic of morphine or scopolamine but the operator should always be gentle in his manipulations."

J. C. M. C.

PINNELL, E. E.: *Use of Intravenous Evipal in Minor Gynecological Operations.* Ohio State M. J. **37**: 449–450 (May) 1941.

"Since 1938 intravenous evipal has been used when possible on the gynecological service as a routine anesthetic for minor operations. . . . This paper has to do with factors bearing on relaxation of the patient, especially the effect of pre-anesthetic medication, and the incidence of certain reactions occurring during and after its use. . . . It was found that 41 cases or 33 per cent showed fair to poor relaxation, requiring supplementary anesthesia in 30 cases or 25 per cent. . . . Most of the patients over 40 years of age were well relaxed. The majority of patients requiring supplementary anesthesia weighed over 60 kg. Most cases with operations lasting more than thirty minutes required supplementary anesthesia. Only 27 per cent of the total patients were colored. . . . Thirty patients or 25 per cent of the total number were apprehensive, 17 of these were poorly relaxed, with 12 requiring supplementary anesthesia. Apprehension is apparently a big factor in poor relaxation and occurs more often in the colored race. . . .

"At the time of administration generalized muscular twitchings were noted occasionally. Vomiting occurred only once. There was one case of hiccoughing of two minutes' duration occurring five minutes after the injection and the patient became moderately cyanotic but responded quickly to carbon dioxide and oxygen inhalations. Post-operatively, moderately severe headaches were occasionally noted, also nausea and vomiting after the evening meal. It was thought a liquid rather than a soft diet would remedy the nausea but the results were approximately the same. . . . Pre-medication of morphine sulphate gr. $\frac{1}{6}$ and atropine sulphate gr. $\frac{1}{150}$ was found to have no definite effect on the relaxation, the change in respiratory rate, or the time required to produce loss of consciousness in the patient. There were several non-serious side-reactions noted but no deaths in over 1800 cases. It was generally agreed by patients to be a pleasant type of anesthesia." 4 References.

J. C. M. C.

PUGSLEY, H. E., AND RICHARDSON, G. D.: *Anesthesia in the Patient with Pulmonary Tuberculosis.* Canad. M. A. J. **44**: 473–476 (May) 1941.

"Patients with active pulmonary tuberculosis usually tolerate anesthesia and operation very well. However, a small percentage develop a post-operative spread of the tuberculous disease in their lungs. This extension of the pulmonary lesion is the principal cause of post-operative deaths and it is the purpose of the present paper to indicate the causes of and measures which will aid in the prevention of this serious complication. . . . We believe that surgical shock results in a lowered resistance to the tuberculous infection and is one of the primary causes of a spread in the lung. Therefore, every effort should be made to avoid the development of shock by careful pre-operative preparation, multiple stage operations where feasible, routine intravenous saline during major surgery, and blood transfusion if signs of shock appear. . . .