cussion and auscultation. The blood pressure was 130 systolic and 90 diastolic. Examination revealed that the baby was in the right occipito-posterior position, that the head was floating and that there was no cervical dilatation. Urinalysis revealed albuminuria (++ degree), and from 8 to 10 red blood cells per high dry field microscopically. The hemoglobin was 9.2 Gm. per hundred cubic centimeters of blood; red blood cells numbered 3,480,000 and the white blood cells 7,350 with a normal distribution. . . .

"Because the patient was a Christian scientist she refused sedation, but on July 4 she acquiesced and, accordingly, at 9:30 a.m. 12 cc. of paraldehyde in 6 cc. of benzyl alcohol and 30 cc. of physiologic solution of sodium chloride were administered rectally. . . . Analgesia was excellent. The patient slept between contractions and became somewhat restless when they occurred. She was taken to the delivery room at 1 p.m. At that time, the anesthetist observed the pulse to be 148 a minute and irregular. The respirations were 48 a minute, deep and labored; the nail beds and ears were cyanotic. She did not seem to respond to the ordinary physical stimuli. Low forceps (Tucker-MacLean) were applied under light ether anesthesia and a living baby girl weighing 9 pounds, 7 ounces (4,280 Gm.) was delivered from the right occipito-posterior position. A second degree midline episiotomy was performed and repaired. A proprietary uterine stimulant 1/320 grain (0.2 mg.) was administered intravenously. She was returned to her room at 2:30, still stuporous, with the pulse regular at 130; respirations remained rapid. . . . One cc. of metrazol was administered intravenously and the patient was placed in an oxygen tent. . . . A total of 20 cc. of nikethamide was given intravenously in divided doses over a period of five and one-half hours, without benefit. An intravenous infusion of dextrose was started. Despite these supportive measures pulmonary edema gradually ensued, and at 5:30 a.m. on July 5 a generalized convulsion occurred. Carpopedal spasm and a positive Chvostek sign were elicited. The patient died at 7 o'clock some eighteen hours after delivery and about twenty-one and one-half hours after administration of the paraldehyde.

"The baby on admission to the nursery weighed 9 pounds 7 ounces. She was cold to the touch and her breathing was shallow. She had repeated bouts of cyanosis followed by convulsions, and despite inhalations of carbon dioxide and oxygen she died thirty-one hours after delivery. An autopsy on the body of the mother, which was performed by the coroner's office of San Francisco twelve hours after death, revealed the following conditions: 'Acute pulmonary congestion and edema, subpleural and subpericardial hemorrhages consistent with asphyxia, pericarditis and adrenal apoplexy. Negative for poisons.' The toxicologist reported only traces of paraldehyde in the blood, urine and gastric contents. An autopsy was not done on the body of the baby." 14 references.

J. C. M. C.

RITTER, J. S., AND KRAMER, S. E.: *Modern Urologic Pharmacology.* Urol. & Cutan. Rev. 45: 695–700 (Nov.) 1941.

"We, as urologists, are ever interested in newer methods and drugs used as anesthetic agents. The margin of safety in our older patients is particularly small. Spinal anesthesia, using 50 milligrams of novocaine or its equivalent under any proprietary name one likes best has proved exceptionally satisfactory. One death, in a very poor cardiac risk, over a period of ten years in our experience would almost ex-

clude the need of searching for a safer anesthetic. Here, let it be said that intravenous saline solution is started as soon as the spinal has been given and continued throughout the operation. A careful check on the blood pressure is also maintained. . . . Paraldehyde, three drams in oil, is injected into the rectum two hours before operation and a second similar dose one hour prior to operation. Nembutal, grain ¾, is given just prior to operation. Local infiltration of the prostate is then done according to the McCarthy technique. This type of anesthesia for resection is of real value to the operator. Spinal and caudal anesthesia produce a complete relaxation of the internal sphincter and prostatic urethra. This frequently gives the operator a false impression as to the size and calibre of the urethral lumen. . . . With local anesthesia this relaxation is not obtained and a more complete resection is obtainable even without the assistant's finger in the rectum. Dr. Borst advised against the use of pentothal sodium as an anesthetic during the administration of sulfanilamide. He stated that the liver is called upon to excrete both these products and in a damaged liver death may ensue. Intravenous anesthesia should never be employed excepting when administered by an expert." 6 references.

J. C. M. C.

NEWMAN, SAMUEL: *Convulsions Associated with General Anesthesia: Report of Three Cases.* Virginia M. Monthly **68**: 655–656 (Nov.) 1941.

"The present state of knowledge or lack of knowledge concerning this syndrome [muscular activity occurring during general anesthesia], as well as its distressing dramatic manifestations, makes the report of cases desirable. . . . Case 1, B. H. D. . . . 4 years old, was first examined March 2, 1932. Three and one-half months previous to examination he had a convulsion. Since then, he suffered what the parents described as 'fainting spells'. . . . Tonsillectomy and circumcision were advised. Three months later (May 21, 1932) both operations were performed under ether anesthesia. The child reacted normally from the anesthetic, recognized his parents, and a few hours later took water and ate some ice cream. About nine hours after the anesthetic, he was seized with epileptiform convulsions and died in an epileptic seizure. This case varies from the typical reported cases of epileptiform convulsions during ether anesthesia in that it occurred, not during, but many hours after, the administration of the anesthetic.

"Case 2, B. Y. . . . was first seen on September 11, 1936, at 3 years and 3 months of age. . . . Examination did not reveal anything abnormal, except congenital obstruction of the posterior nares. He was referred to a rhinologist, who relieved the obstruction by operative procedure. The child was seen again on April 19, 1937, when he was 3 years and 10 months old. The complaint then was that he was nervous. His breathing on that occasion was rather rapid and sounded asthmatic. While apprehensive and very nervous, he did not give the impression of being in any way mentally abnormal. Examination revealed a mild degree of undernutrition and anemia. May 30, 1938, eleven months after an attack of whooping cough, he was seen again (5 years of age). The parents stated that the boy was weak, though his general appearance was healthy. His breathing was noisy. Examination did not show any asthma. The tonsils were found to be enlarged. Sedative medication, tonics, cod liver oil, and adequate rest were prescribed. The parents were told that the noisy breathing might be due to adenoids aggravated by enlargement of the tonsils. Tonsillectomy and adenoidectomy were recommended.