

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 $\frac{3}{4}$, 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.

Subsequently, the child was taken to Duke Hospital. Hyperpnea and marked hypertrophy of the tonsils and adenoids, stenosis of the right naris, posteriorly, and lack of normal rise in the blood-sugar curve were noted. . . . September 3, 1938, at 5 years and 2 months of age, tonsillectomy and adenoidectomy were performed. He reacted normally to the operation. The morning following the operation the child was in a profound coma and slightly cyanotic. Breathing was fast and labored, and the pulse faint and rapid. Twenty cc. of 5 per cent dextrose solution was given in the external jugular vein. Blood-sugar determination in the laboratory before administration of the dextrose was reported as 30 mg. per 100 cc. A few hours later the pulse was imperceptible and the child looked moribund. Twenty cc. of 50 per cent glucose was given in an arm vein, followed by 100 cc. of 5 per cent dextrose in Ringer's solution. The general appearance of the child and the pulse improved rapidly. Towards evening, his pulse was full and strong; he was able to take food. Monday, September 5, he seemed well. Tuesday, September 6, the child was taken home in apparently good condition. A few hours later he became cyanotic, dyspneic, and comatose. Twenty cc. of 50 per cent glucose was administered intravenously and 5 cc. of calcium gluconate intramuscularly. He regained consciousness slowly. The temperature was 103.7. Generalized twitchings or athetoid movements of the upper extremity were noticed. A blood-sugar, taken at 11 a.m., before administration of glucose, showed 133.3 mg. per 100 cc. Blood-sugar at 5 p.m. was 133.3 mg. per 100 cc. The child progressively improved. Sunday, September 11, he appeared to be normal. . . . April, 1939, when he was 5 years and 10 months, he had a typical grand mal convulsion. Since then, he has been

suffering marked mental deterioration.

... "Case 3, J. G. C. . . . was first examined July 15, 1939, when he was 2 years of age. . . . Examination did not reveal anything abnormal. . . . July 27, 1940, at 3 years of age, laparotomy was performed for a ruptured appendix. The appendix was removed, drains were inserted, and the abdomen closed in the usual manner. After the last skin suture had been put in, the child had typical epileptiform seizures, which terminated fatally. The convulsions in the last case may not have been due to anesthesia. It is possible that they were due to embolus, yet, because of the possibility of their having been due to anesthesia, the report of this case seems justified." 2 references.

J. C. M. C.

HANLEY, B. J.: *Obstetrical Analgesia in Private Patients*. Am. J. Surg. n.s. 54: 403-406 (Nov.) 1941.

"It is pretty generally agreed that the amelioration of pain during labor is desirable although the ideal analgesia is yet to be evolved. . . . Common usage interprets the word analgesia to mean both a lessening of pain and loss of memory. This, of course, is not strictly correct, but will be used in this sense in this paper. . . . A series of 312 private cases of labor are reported in which nembatal and scopolamine were used to induce analgesia. Good results were obtained in 82 per cent. Most of the patients failing to respond were in hard labor before analgesia was started and hence the drugs had insufficient time to induce sleep. There were no severe maternal complications in this series. Ten patients were markedly restless and difficult to control. One baby, 0.32 per cent, was stillborn due to a prolapsed cord which was in no way related to analgesia. Six babies were deeply asphyxiated at birth and