

electively to relieve the usually innocuous pains of labor is unjustifiable. Since the recent advent of continuous caudal analgesia four women have lost their lives because of the procedure per se. There have been other 'close calls' reported. There must be other fatal or near fatal accidents which were not reported. . . .

"The test of time will put continuous caudal analgesia in its approximate place in obstetrics and until this comes about we must hope that the minimum number of mothers will suffer harm." 13 references.

J. C. M. C.

FATTI, L., AND MORTON, H. J. V.: *Pentothal Anaesthesia in Bronchoscopy*. Lancet 1: 597-598 (May 6) 1944.

"Local anaesthesia for bronchoscopy, using cocaine or newer substitutes . . . is probably employed in most clinics in this country. With the introduction of barbiturates of very rapid action it has become possible to spare the patient discomfort by superimposing light general anaesthesia on adequate local preparation. . . . During the past five years we have evolved a technique which . . . has proved highly satisfactory in the last 600 consecutive cases. . . . The average adult receives 'Omnopon' grain 1/3 and hyoscine gr. 1/150 an hour before operation; the dose is reduced for extremes of age or debility. It is essential that the hyoscine should take full effect, as shown by dryness of the mouth; if it does not do so, atropine sulphate gr. 1/100 intravenously may be given in addition. We are convinced that premedication helps to prevent spasm. . . . The patient is placed on the operating table with his head on the bronchoscopic head-rest and given 10 per cent carbon dioxide in oxygen to breathe through a tube. . . . As soon as hyperpnoea begins pentothal is injected. The average dose for an adult has been 8 c.cm.

of a 5 per cent solution injected during 30 seconds. Slower injection, particularly of a 2½ per cent solution, has been found unsatisfactory. Reduction in dose is made for age or poor general condition. The optimum dose is the smallest which will adequately relax the jaw muscles. When the mouth can be opened easily the injection is stopped and the glottis immediately exposed with a laryngoscope. During this preliminary laryngoscopy the anaesthetist continues to offer the carbon dioxide-oxygen mixture through Denis Browne's mouth-tube hooked into the corner of the mouth, thus maintaining stimulation of respiration. In nearly every case the larynx is found open and introduction of the bronchoscope is straightforward. In the few cases in which the larynx remains closed, on no account should any tentative movement of the bronchoscope be made; the bronchoscopist must wait until the cords open spontaneously—usually with a cough and without undue delay, if the technique has been carefully followed. After introduction of the bronchoscope oxygen is passed briskly through the side tube on the instrument, assisted by momentary positive pressure and by further carbon dioxide in the occasional case where spontaneous respiration is momentarily inadequate. A small additional dose of pentothal may be needed if the investigation takes long or the patient resistant. At the end of the operation the bronchoscope is slowly pulled up until the end lies just distal to the larynx.

"The carbon dioxide mixture is then delivered again until definite hyperpnoea is evident, when the bronchoscope is carefully withdrawn. This manoeuvre will usually prevent a withdrawal spasm. Should some degree of spasm develop however, 10 per cent carbon dioxide in oxygen can be given through a mask and airway under

pressure immediately on withdrawal of the bronchoscope, and the vicious circle of asphyxia is thus broken at its inception. . . . The method is suitable only for the experienced bronchoscopist." 8 references.

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DONNELLY, J. F.: *Analgesia in Obstetrics*. Am. J. M. Sc. 207: 804-811 (June) 1944.

"The purpose of this paper is to discuss the drugs which are given during childbirth; to relieve pain, to provide the loss of sensation, or to render the parturient amnesic for the pain. The terms analgesia, anesthesia and amnesia are used to describe the preceding effects. These terms are used interchangeably in this paper. . . . Morphine and its related compounds have excellent analgesic properties. . . . In a recent article Mengert concluded that the greatest fetal respiratory depression occurs during the third hour after the administration of morphine and that it should be avoided in premature labors. He feels that, with careful supervision and with adequate resuscitation facilities, it can be used safely. We use morphine sulfate analgesia frequently at the Hospital of the University of Pennsylvania and feel that it is safe when Mengert's warnings are observed. Although heroin and dilaudid produce less fetal depression they are not widely used. . . . According to Stander, barbituric acid derivatives are the analgesic drugs most commonly used in this country. They do not relieve pain but make the patient amnesic. Of these derivatives, pentobarbital is used most widely. . . . Rectal ether, chloral hydrate and paraldehyde are given less frequently than morphine or the barbiturates in labor. They do not produce amnesia as satisfactorily as do the barbiturates and do not offer any greater safety. Nitrous oxide, ethylene, ether and chloroform are well-known inhalation anal-

gesic agents and will not be discussed. Two newer analgesic agents, vinethene and cyclopropane, are in the process of evaluation. . . . The safety of spinal analgesia has been debated since Conroy reported its successful use in 1934 for Caesarean section. . . . On account of the potential dangers associated with spinal analgesia it can be used only where proper facilities are available. . . . Although some authors think that intravenous analgesia is safe, it is not generally believed to be safe enough for use in obstetrics. Kroger and DeLee reported upon the use of hypnosis to produce analgesia during labor and delivery. They confirmed the observations of others who have used it with success. The low risk to the mother and baby warrant further investigation of this method. No comments need be made on the use of puerperal field block. It is a simple, inexpensive and satisfactory method of relieving perineal pain for delivery.

"The use of Demerol and the introduction of continuous caudal analgesia are the two outstanding new developments in obstetrical analgesia. . . . In spite of recent innovations in the field of obstetrical analgesia, the ideal is yet to be found." 40 references.

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MACINTOSH, R. R.: *Publication of Anaesthetic Misadventures*. Brit. M. J. 1: 633-634 (May 6) 1944.

"Dr. John Elam has campaigned persistently for safer anaesthesia. . . . The pages of the medical journals testify that anaesthetists, like other mortals, rush into print more readily with their successes than with their tragedies—yet it is from the latter that more can be learnt. Anaesthetic misadventures are not rare. The accidents I have heard of recently varied considerably in character. One can well imagine the mortification of giving pentothal