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.

J. C. M. C.

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 analgesic 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 Cosgrove 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 pudendal 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.

J. C. M. C.

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

intra-arterially on two dfferent occasions, each followed by amputation; the paralyzing effect of injecting the wrong drug intrathecally; the tragedy of leaving the anaesthetized patient unattended for a short period to find him dead on return; of having been responsible for an explosion through ignorance of elementary physical facts; of giving chloroform under the impression that the bottle contained ether; of giving a lethal overdose of pentothal, or of local anaesthetic drugs such as cocaine and amethocaine. The cause of tragedies such as these is obvious; others are not so overt. Death on the table is a clinical problem, and in the great majority of cases the anaesthetist is the only one who can give a clue as to what went wrong; if he is frank enough to give a detailed anaesthetic history of the sequence of events prior to death his story will be far more illuminating than the most searching necropsy. A striking fact is that anaesthetists seldom make the same mistake twice. . . . The publication of anaesthetic misadventures in a form in which the victims can be identified by the lay public is obviously undesirable. I think, however, they could be collected and published in book form from time to time. To avoid social or legal repercussions it might be desirable to confer anonymity on the anaesthetist. The Association of Anaesthetists is now a large and powerful body. A Misadventure Subcommittee might be formed to which fellows and members could bind themselves to notify their misadventures. There would soon be available valuable reference books of what not to do. Alternatively, an investigation on these lines might be undertaken by some scientific or philanthropic body with adequate funds at its disposal. Such an investigation would pay a good dividend in terms of human life."

J. C. M. C.

SALAND, GAMLIEL AND KLEIN, CHARLES. *The Evaluation of Alcohol Lumbar Paravertebral Block in Peripheral Vascular Disease.* Am. J. M. Sc. 207: 749–753 (June) 1944.

"The use of alcohol to produce block of the sympathetic ganglia was first introduced in this country by Swetlow in 1923. Since then, various workers in the field of peripheral vascular diseases have used this procedure to induce vasodilatation in the lower extremities and obtain relief from ischemic symptoms and signs. No one has as yet determined objectively how long this vasodilatation exists. . . . In the past, particularly in the cases of angina pectoris, the evaluation of the effect of such injections has been made according to the patient's subjective feeling and, as in other evaluations, the patient's symptoms are unreliable criteria for determining the efficacy of a therapeutic procedure. It is well known that symptoms of vascular disease may be relieved spontaneously and so we thought it would be important for us to know by an objective method exactly how long one may expect the vasodilatation in the lower extremities to last after the injection of the lumbar vertebral ganglia with alcohol. . . . We therefore tried to determine objectively: (1) exactly how long one may expect vasodilatation effects to last after alcohol paravertebral block in the lumbar region; (2) whether neuritis is produced by such a procedure, and if so, how often, how severe, and how long such neuritis might last; (3) whether the amount of alcohol used was a factor in producing vasodilatation or neuritis; (4) whether the use of novocaine in sweet almond oil would reduce the incidence of neuritis; (5) incidentally, we tried to determine if claudication time would be altered by such therapy. . . . The patients studied were those who applied to the vascular clinic for relief of