mately 1,200 cases were anaesthetized by me during this time. Pentothal alone was the drug used in 80 per cent of the cases; cyclopropane, with or without the addition of nitrous oxide or occasionally ether in 10 per cent; local anesthesia in 5 per cent; and intravenous morphine in 5 per cent. The cyclopropane was reserved for the penetrating wounds of the abdomen, the thoraco-abdominal wounds, and those few cases which were regarded as very bad risks and had failed to respond to resuscitative measures. It was found to be of great value in all these cases. . . . The machine used was a Rochester Lundy Heidbrink. It has travelled many hundreds of miles over bad roads and tracks, and has been packed and repacked many times without damage. Two hundred and seventy gallons of cyclopropane have been used for 120 operations. The economy in cylinders thus effected is most striking. If semi-closed nitrous oxide, oxygen, and ether had been used in these cases about 120 100-gallon cylinders of nitrous oxide would have been required instead of the three cylinders of cyclopropane of the same size."

J. C. M. C.

NIXDORF, W. B.: *Anesthesia Department Report, with Pertinent Comments.* Harper Hosp. Bull. 2: 25–29 (Apr.) 1944.

"Three significant trends have developed in the Anesthesia Department [Harper Hospital, Detroit] during the past year: 1. More extensive use of local block anesthesia with or without intravenous sodium pentothal. 2. Replacement of procaine with monocaine formate for block anesthesia. 3. Substitution of the ureteral catheter technique for the Lemmon technique in continuous spinal anesthesia. While local block anesthesia with intravenous sodium pentothal has not been too generally employed in the past, it has been found extremely useful for a variety of reasons during the past year. In most instances, the anesthesia has been highly satisfactory, particularly in those cases which would have survived no other anesthetic procedure. It is to be remembered that the local block is the major anesthesia, while the pentothal is only a secondary analgesic agent. After premedication with no more than 1/8 gr. morphine sulphate most cases have required only 15–25 cc. of a 2½ per cent solution of sodium pentothal for abdominal procedures lasting 30 to 90 minutes. . . . Replacing procaine is a relatively new local anesthetic, monocaine formate closely related to the older monocaine hydrochloride that has been in common use by the dental profession. . . Experience indicates that the drug is more efficient in a 1 per cent solution than any other similar agent in a 2 per cent solution. It has been used without the addition of a vaso-constrictor. Its toxicity is low, comparing favorably with that of metycaine. The duration and depth of anesthesia produced has exceeded our fondest hopes. This is, of course, a tentative opinion because of the small number of cases in which it has so far been used. The drug is of no particular value for subarachnoid use since its action seems to be somewhat delayed and there is only slight increase in the duration of anesthesia. This, combined with an extremely rapid rate of diffusion in the spinal fluid, making the drug dangerous except in the most careful and adept hands, has caused us to discontinue its use for this purpose. . . . Because it has a greater margin of safety than any other cocaine derivative, procaine remains the drug of first choice for intrathecal anesthesia."

J. C. M. C.

KELLY, F. H.: *Anesthesia of Protoplasm.* J. Indiana M. A. 37: 17–18 (Jan.) 1944.

"The principle upon which the ice treatment is based is not a freezing process but one of chilling the protoplasm. When the temperature of the tissue is brought down to between 35 and 40 degrees Fahrenheit the activity of all protoplasm is inhibited. . . . We are very enthusiastic about this method, for in my thirty years of practice about 98 per cent of our diabetics died following amputation, whereas now, with the anesthesia of protoplasm, 98 per cent are living, and the two first cases have been wearing artificial legs for over eighteen months."

J. C. M. C.

FAULKNER, R. L., AND RIEMENSCHNEIDER, E. A.: *Postoperative Care and Complications of Gynecological Patients.* Ohio State M. J. **40**: 639–642 (July) 1944.

"Morphine and plenty of it is the general practice following pelvic operation. . . . It is well to remember that morphine may prolong the period of nausea in some patients and these should be given pantopon or dilaudid which may be better tolerated. After three or four days codein may be utilized. A milder sedative or hypnotic at bed time may decrease somewhat the amount of narcotic needed. . . . In pelvic surgery there should rarely be serious shock without excessive loss of blood since operations in the lower abdomen are generally well tolerated. . . . Atelectasis is usually the earliest pulmonary complication following operation. . . . Postoperative pneumonia is essentially the same as pneumonia affecting the patient at any other time."

J. C. M. C.

LENAHAN, N. E.: *New Methods of Anesthesia and Their Application in Office Practice.* Ohio State M. J. **40**: 643–649 (July) 1944.

"Many times anesthesia of a part or area is required and no available anesthetist or anesthetic equipment is available. In this case the blocking of the nerve or infiltrating the area with novocaine or related compounds proves very effective." 5 references.

J. C. M. C.

WHITE, C. S.: *Demerol—a Substitute for Morphine in Surgical Practice.* Virginia M. Monthly **71**: 351–353 (July) 1944.

"We have been using Demerol in a surgical practice for more than a year. . . . For the relief of pain, particularly of a spasmodic character, such as renal or biliary colic, it is a very satisfactory substitute for morphine. The dose has been 100 mg. hypodermically or intramuscularly. . . . Demerol does not induce sleep, but sleep frequently follows the relief of pain. Following operation, it is given every three or four hours during the first 24 hours, its administration being left to the discretion of the nurse—then about twice in the next 24 hours. Thereafter, mild sedatives are substituted and usually suffice. We have found Demerol particularly useful in those patients who tolerate morphine poorly or have an idiosyncrasy for the drug. . . . We have not seen the depression in respiration, cyanosis, pruritis or excitation which is occasionally noted after the administration of morphine following the use of Demerol, possibly because we have been satisfied with a conservative dosage. Our experience is limited almost exclusively to surgical cases. In about fifty cases in which it was used as a part of the preparation for a general anesthetic, it seemed to relax the patient but did not produce narcosis to any degree. Combined with one of the barbiturates, seconal for instance, it formed a most satisfactory substitute for morphine and atropine, and we believe it can be relied upon to eliminate the excitation