"Pituitrin may produce reactions of three types: anaphylactic, cardiac, or respiratory. The first is not particularly dangerous, especially when not in conjunction with cyclopropane anesthesia, and the recovery from the shocklike symptoms with urticaria, itching, and angioneurotic edema is rapid upon the administration of a few minims of adrenalin. Pituitrin shock due to the action of the pressor fraction on the heart is attributed to coronary constriction followed by myocardial anoxia, dilatation of the heart, decrease in cardiac output, and fall in blood pressure, with sometimes a fatal outcome. The respiratory reactions are signified by bronchoconstriction of varying degree, simulating an asthmatic attack. Pituitrin is marketed in two forms, which vary only in strength, obstetrical pituitrin having 10 units per cc., and the surgical form 20 units per cc. It has been broken up into its fractions, and is obtainable as 'pitocin,' containing the oxytocic fraction with a very small amount of the pressor fraction, and 'pitressin,' which is almost purely the pressor fraction with only slight contamination by the oxytocic fraction. Pitocin, rather than pituitrin, is then evidently the drug of choice in obstetrics. The combined use of cyclopropane and pituitrin is fraught with danger since they are both parasympathetic stimulants. In the circulatory system they have a synergistic tendency toward the production of hypertension and/or cardiac arrhythmias. From the parasympathetic stimulation of the respiratory tract they may produce laryngospasm, crowing, stridor, or bronchoconstriction, which may range from asthmatic wheezing to massive collapse of the lungs. The bradycardia often seen may be due to vagal stimulation, direct myocardial action, or intense coronary constriction. . . .

"Although pituitrin has been used in connection with cyclopropane in many cases where no untoward reactions were noted, this does not absolve the combination of blame. . . . Greene has recommended adding ether to the anesthetic mixture if pituitrin is to be used, depending upon the sympathetic action of the ether to counteract the parasympathetic effects of the pituitrin and cyclopropane. . . . Pitocin, the oxytocic fraction of pituitrin, is just as good in causing uterine contraction without any of the side effects of pituitrin, and in many obstetric clinics has supplanted it. Ergonovine in any of its forms is an excellent and rapidly acting oxytocic and can be used for this purpose instead of pituitrin. By using either of these alternatives, an extremely unfortunate accident can be avoided." 5 references.

J. C. M. C.

CALVERT, WALTER: *Trichlorethylene and Midwifery.* J. Obst. & Gynec. Brit. Emp. 51: 140–143 (Apr.) 1944.

"An investigation into the use of trichlorethylene in midwifery has been made. The results are encouraging and suggest that painless delivery could be brought within reach of more women. A short addition to the gas-air course might make this method available to unsupervised midwives." 9 references.

J. C. M. C.

CONROY, W. A.: *Analgesia and Anesthesia for Obstetrics, Inhalation Methods.* Am. J. Obst. & Gynec. 48: 81–84 (July) 1944.

"The obliteration of the pain element of labor contractions is readily accomplished without loss of the patient's cooperation, and without interference with the strength of contractions, or danger to the fetus. Nitrous oxide, combined with oxygen inhalations and supplemented during expulsion, has been found adequate and

safe in the hands of many. It, and the apparatus for its administration, are available almost universally now, and personnel who know its use are much more plentiful than for the more complicated procedures frequently advocated." 1 reference.

J. C. M. C.

JOHNSON, W. B., JR., AND RUZICKA, E. R.: *Endotracheal Anesthesia for Dental and Oral Surgery.* U. S. Nav. M. Bull. **43**: 304–307 (Aug.) 1944.

"Endotracheal anesthesia when used in cases of multiple extraction of teeth, with alveolectomy or other necessary procedure to prepare a mouth for dentures, has been instrumental in returning men to duty from 4 to 6 weeks sooner because of more rapid tissue repair, absence of infection, and the completion of the procedure in one operation. . . . The aspiration of blood, mucus, vomitus, pus, and foreign bodies, such as fractured teeth, into the trachea is prevented. Intubation also enables the anesthetist or operator to remove material from the bronchial tree by suction through or alongside the endotracheal tube. Not the least important advantage is that the anesthetist may be removed to a distance from the operating field and still retain complete control of the patient. This point is of technical value in all dental and oral procedures in which general anesthesia is used. Finally this type of anesthesia enables the oral surgeon to complete the procedure unhurriedly even in the face of untoward complications. . . . The disadvantages of endotracheal anesthesia appear in the act of intubation and management of the method when the tube is in place. . . . Intubation when performed with laryngoscopy requires anesthesia of sufficient depth to relax the mandible and depress the pharyngeal and laryngeal reflexes. Such depth of anesthesia is often not necessary for dental and oral surgical procedures in which endotracheal anesthesia is desired. In the series of cases cited here, however, little anesthetic agent was required once the endotracheal tube was in place. . . . To secure the necessary depth of anesthesia for intubation, more time must be spent in induction of anesthesia. . . . There is no evidence that endotracheal anesthesia increases the incidence of serious respiratory complications postoperatively." 1 reference.

J. C. M. C.

BUXBAUM, HENRY: *Local Anesthesia.* Am. J. Obst. & Gynec. **48**: 90–93 (July) 1944.

"It has been satisfactorily demonstrated that all major and minor obstetric procedures either by the abdominal or perineal routes can be done under local anesthesia with the possible exception of version. An absolute indication for the use of local anesthesia may be found in patients with upper respiratory infections, pulmonary tuberculosis, asthma and cardiac disease with the omission of the adrenalin. Relative indications are pre-eclamptic toxemia, nephritic toxemia and diabetes. It is also the ideal approach in all cesarean sections with or without sterilization. Here one may use intravenous anesthesia in addition for closure if necessary. In the delivery of a breech presentation, parasacral or pudendal block is especially efficacious due to the relaxation of the pelvic floor and levators. Even if the operator should elect to use inhalation anesthesia, delivery is definitely facilitated by the addition of pudendal block. . . The infiltration method is the most commonly used form of local anesthesia in cesarean sections, although one can block the nerves at the semilunar line if he so desires. . . . To demonstrate the practicability and safety of re-