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-