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-

gional and infiltration anesthesia, let me briefly cite the statistics of the operative and spontaneous deliveries done at the Chicago Maternity Center with this method of anesthesia. Here, as you are aware, all deliveries are done in the home under the poorest of physical and sanitary environments. . . . Up to the present time, from the inception of the institution in 1932, parasacral anesthesia has been utilized in 550 cases, and pudendal block in 2,200 cases, with no maternal or fetal deaths attributable to the anesthetic. There were two cases of abscess formation at the site of puncture. No needle was broken off in the tissues. . . . In the 550 cases where parasacral anesthesia was employed, 314 (57 per cent) were ideal; 203 (37 per cent) were satisfactory; and only 33 (6 per cent) were failures. In the pudendal block group, 880 cases (40 per cent) were ideal; 1,210 (55 per cent) were satisfactory; and 110 (5 per cent) were failures. In the parasacral series, all forms of pelvic obstetric surgery were performed with the exception of version. This includes manual and instrumental rotations and difficult midforceps operations. In those cases in which the pudendal block anesthesia was used, the operations were mainly low forceps deliveries, episiotomies and repairs. This was also the procedure in all breech deliveries. . . . Inasmuch as local anesthesia has proved so satisfactory in home obstetrics, it certainly can and should be employed more often in hospital practice, particularly in this day and age, where the anesthetic departments in most hospitals have been so badly depleted."

J. C. M. C.

Egan, R. L.: *Refrigeration Treatment of Peripheral Vascular Diseases.* Nebraska M. J. **29**: 217–218 (July) 1944.

"Refrigeration combined with measures to combat spasm of collateral arterial circulation may safeguard against or minimize gangrene resulting from arterial occlusion. It is a valuable agent in the preparation of the poor risk patient with vascular disease for lifesaving surgery and when used as an anesthetic procedure has valuable advantages over conventional methods." 10 references.

J. C. M. C.

Ellis, G. J., and Sheffery, J. B.: *Further Observations on Continuous Caudal Anesthesia.* M. Ann. District of Columbia **13**: 258–262 (July) 1944.

"Since our original article on 100 obstetrical cases delivered under continuous caudal anesthesia, we have used this method in an additional 125 cases. . . . There has been no mortality or morbidity in our series of 225 cases attributable to the anesthetic. . . . Strict adherence to technic, early recognition of complications, and the facilities for prompt treatment will keep accidents at a minimum." 8 references.

J. C. M. C.

Fitzgerald, J. E.; Thomson, J. M., and Brown, H. O.: *Continuous Caudal Anesthesia with Pontocaine: Obstetrician's Viewpoint.* Am. J. Obst. & Gynec. **48**: 94–99 (July) 1944.

"The following report is a preliminary presentation based on the first 200 cases in which repeated caudal injections of pontocaine were used to produce and maintain anesthesia during labor, and covers the five-month period between March 16 and August 26, 1943 [Cook County Hospital]. . . . There were only 3 definite failures due to inability to locate the caudal canal. In 10 patients there was initially complete relief, but later the needle became dislodged (5 cases) and was not