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