both groups of mice. . . . The ease with which viral pneumonia is produced in animals under ether anesthesia is referred to the ready aspiration of the viral suspension by the unconscious animals rather than to an increased susceptibility of the respiratory mucosa produced by ether."

J. C. M. C.

FELDMAN, M. H.: *Oxygen-want in General Anesthesia.* Am. J. Orthodont. & Oral Surg. **32**: (Oral Surg.) 52–58 (Jan.) 1946.

"When the body tissues fail to receive an adequate supply of oxygen during the process of the interchange of gases we call 'respiration,' a condition of anoxia ensues. This state may be induced by various conditions, chief among which are: low oxygen tension in the inspired atmosphere, a poisoning of the inspired air by some inert gas, by high altitudes, and by various physiologic disturbances arising from asthmatic or pneumonococcic infections. For the dental anesthetist, the problem of anoxia resolves itself into a desire to be on the alert to prevent displacement of the essential oxygen content of the blood and body tissues by other gases which may hinder the normal functioning of heart, brain, and kidneys. . . . It is because anoxia is always present when nitrous oxide is inhaled for complete anesthesia that I feel the need very urgent for the profession to make an honest and courageous reappraisal of its attitude toward this agent. . . . It has been my procedure for some time, to administer as high as 50 per cent of oxygen with my anesthetic gases. This I do on the theory that if it will help the heart and circulatory system to supply an excess of oxygen reserve, I am in no way jeopardizing the patient for whom the ordeal of undergoing an anesthetic experience may be a strain. . . .We owe a duty to society to heed the message of caution. To fail to amend our anesthesia procedures in the interest of safety is unwarranted. We have a challenge that merits logical debate. It is going to be difficult to change the attitude of the profession toward an agent about which a century-old tradition has been built. But it must be done."

J. C. M. C.

ROVENSTINE, E. A., AND STRAUSS, HYMAN: *Anesthesia Management of Patients with Respiratory Paralysis Requiring Laparotomy.* Am. J. Obst. & Gynec. **51**: 213–216 (Feb.) 1946.

The anesthetic management of a patient with acute anterior poliomyelitis and respiratory paralysis who required cesarean section is described. The condition was further complicated by pyelonephritis and acute glomerulonephritis, the absence of cough reflex and prematurity. Passive movement caused severe pain.

The existing nephropathy was considered reason for avoiding ether, chloroform and, to lesser extent, the intravenous barbiturates. Postanesthetic nausea and emesis, which may be serious complications for a respiratory patient without cough reflex, were further reasons for not employing volatile agents. Anesthetics thus were limited to the gases, intravenous and regional methods. The latter seemed undesirable due to time factor, the necessity for artificial respiration and the pain on movement. Intravenous barbiturates were opposed as an additional burden of detoxification and elimination and possible adverse effect on the fetus.

Of the gases, cyclopropane was the optimum choice, due to its potency, admission high oxygen concentration, adaptability to controlled respiration, and negligible concentration in fetal circulation.

Controlled respiration is more easily performed when a functioning air-way is assured with endotracheal catheter in place. This may be placed in a conscious patient by application of local anesthesia to the upper air passages. Well fitted face mask and rebreathing bag with carbon dioxide absolute unit complete the apparatus.

No preanesthetic medication was given, in order to avoid any effect upon the fetus.

The patient was anesthetized and an endotracheal tube placed while in the respirator.

The anesthesia was then discontinued, and the patient removed to the operating room. After surgical preparation, cyclopropane-oxygen was administered by manual respiration. The infant was quickly delivered during an uneventful anesthesia. Results were considered entirely satisfactory.

M. F. P.

HABEEB, ALFRED: *Choice of Anesthetic in Urological Surgery.* South. M. J. 39: 149–154 (Feb.) 1946.

"In spite of the fact that the urological surgeon, in the large majority of his cases, is faced with the problem of operating upon an elderly individual, and that most of these patients present complicating pathology, such as cardiorenal disease, hypertension, diabetes, and a low renal function, it must be granted that tremendous improvement in mortality and morbidity figures has been made in recent years. . . . In our practice at the Employee's Hospital, as well as in our private work in Birmingham, spinal anesthesia has been the choice for all of these major surgical cases. . . . Premedication should be considered as part of the actual anesthesia. . . . Regardless of the anatomical position of our surgery, that is, whether in the transurethral, suprapubic or lumbar regions, spinal anesthesia is our choice anesthetic agent. . . . A patient under spinal anesthesia must be watched very closely and the pressure checked every few minutes. Mask oxygen proves to be one of the best drugs in controlling pressure. . . . If oxygen fails to stabilize the pressure, we next resort to one of the vasoconstrictor drugs. . . .The average dose of 'pontocaine' solution used intraspinally in our series of prostatic resections was 8.5 mg., with the addition of 1 c.c. of 10 per cent glucose to make a hypertonic solution. . . . Many of you are doing kidney surgery under sodium 'pentothal.' We cannot altogether agree with this choice, for we believe that spinal anesthesia supplemented with sodium 'pentothal' or cyclopropane, meets the physiological requirements more adequately, and most certainly affords a maximum relaxation."

J. C. M. C.

BREWER, LYMAN; BURBANK, BENJAMIN; SAMSON, PAUL C., AND SCHIFF, CHARLES A.: *The "Wet Lung" in War Casualties.* Ann. Surg. 123: 343 (Mar.) 1946.

No more serious problem was encountered by the surgeons in Forward Hospitals treating thoracic wounds than the therapeutic problem of the wet lung. By wet lung is meant the persistence of fluid in the pulmonary tree. There are two groups of factors which are important in the development of wet lung:

1. Forces leading to the production of secretions and other fluids in abnormal amounts in the respiratory tract.
2. Conditions preventing adequate removal of the fluids so produced.

Experimentally, it has been shown that any appreciable trauma to the chest wall was followed almost immediately by widespread bronchial spasm and increased bronchial secretion. Ab-