

LENAHAN, N. E.: *Indications and Contraindications for Spinal Anesthesia*. Ohio State M. J. 43: 626-627 (June) 1947.

Contraindications and indications for spinal anesthesia are more or less relative. Often it is not the agent used that determines the success or failure of the method, but the skill and ability of the individual using the drug. Many indications and contraindications are mentioned by five authors picked at random. These are listed in outline forms.

F. A. M.

LINDGREN, INGA: *Cutaneous Precordial Anaesthesia in Angina Pectoris and Coronary Occlusion (An Experimental Study)*. *Cardiologia* 11: 207-218, 1946-1947.

Sixteen patients who had angina pectoris were studied. They were subjected, under standard conditions, to hypoxemia or exercise. When the pain appeared the area of pain was mapped out both on a chart and with iodine on the skin of the patients. The areas were injected with 1 per cent procaine solution without adrenalin. Ten to 25 ml. of solution was the usual amount used. At first, intracutaneous anesthesia was used, but for technical reasons the later experiments were done subcutaneously. The test was repeated after the injection. Improvement of the electrocardiogram was obtained in 14 of the patients. In 2 spontaneous attacks of angina pectoris in 2 separate patients, precordial anesthesia was used. In both patients the acute electrocardiographic change, which occurred during the attack, disappeared after the anesthesia. Relief of pain of coronary occlusion can be relieved in the same way as anginal pain, although the electrocardiographic changes were not effected by the anesthesia. Drawings show the areas of pain in several patients. 13 references.

F. A. M.

MADAN, K. E.: *Spinal Analgesia with Sacral Escape*. *Indian J. Surg.* 8: 191-193 (Dec.) 1946.

In the ordinary spinal analgesia, the result is a complete paralysis of all sensory and motor nerves from the toes up to the segment desired. It seems unnecessary that, for abdominal operations, all the lumbar and sacral nerves be paralyzed. Often there is retention of urine, which is undesirable and unnecessary. A modification of the technic of spinal analgesia which allows the sacral nerves to escape has been worked out.

With the patient in the lateral position, the thighs are flexed well up on the abdomen. With a hyperbaric solution, before giving the spinal anesthetic, the pelvic end of the table is raised to 15 degrees and the head end is raised to 5 degrees. One or two pillows are placed under the head and neck. The position of the table appears to be like a broad letter V. The whole table is then tilted to Trendelenburg position. The most dependent portion of the spine is now the region of the third or second lumbar vertebra. The object of the position is to straighten up the lower end of the spine and entrap the solution in the mid lumbar and lower lumbar region. It is prevented from entering the sacral concavity, so all the sacral nerves and the sacral center of micturition escape the effects of the anesthetic. By modifying the technic the escape of the sacral nerves is successfully obtained with either unilateral or bilateral analgesia, and with heavy, light or isobaric solutions.

The injection is given slowly. No barbotage is employed. After the injection, the patient is turned onto his back with both thighs still well flexed. This position is maintained for about three minutes. The legs are then straightened. The test of the success of the method is that sensations over

the perineum, scrotum and penis in the male, and of the vulva in the female are present. Some areas on the back of the lower limbs remain sensitive. The method permits the micturition reflex to remain active.

F. A. M.

RINK, E. H.: *The Care of the Anesthetised Patient*. Guy's Hospital Gazette 61: 182-186 (July 5) 1947.

When the patient is anesthetised, he is deprived not only of his consciousness, but also of his reflex defences against incidental trauma, heat and cold. In addition, there is a derangement of the temperature regulating mechanism. It is the responsibility of the anesthetist to protect the patient while he is in this defenseless condition. After premedication or a basal anesthetic has been given, the patient may lose some or all of his defenses. During the induction of anesthesia the patient should be protected against possible injury. The best way of restraining a patient during this stage is to hold both of his elbows firmly down on the table. The lower half of the body is best restrained by the full weight of a body across the patient's thighs. Some other person besides the anesthetist should always be present during any induction period.

During the time of operation the patient should be placed on the table in such a way that the arms will not fall over the edge of the table. All points of possible pressure should be protected. The operating theater should be kept warm and the patient protected from draughts. A light blanket should cover the body. After the operation the patient requires constant watching. An unconscious patient should never be left unattended. Care should be taken of the airway. Aspiration of vomitus into the air passages should be avoided. A good light is important in the care of a patient

after anesthesia. Cyanosis may go undetected in a dimly lighted room.

F. A. M.

ROBERTSON, R. B.: *Pentothal Sodium and a Combination of Pentothal Sodium and Curare as an Anesthetic for Tonsillectomy*. Arch. Otolaryngology 45: 392-397 (Apr.) 1947.

Two groups of patients who had tonsillectomies, were given pentothal sodium. In group I the patients received pentothal sodium and topical anesthesia, and the tracheas were intubated. In the second group the anesthesia consisted of essentially the same technic, but curare was given before intubation and when necessary during the operation. The patients in group 1 reacted, on the average, in seventy-five minutes; those in group 2, on the average, in twenty-five minutes. The first group required attention during the postoperative period because they were boisterous and somnolent; the second group, after the initial awakening, settled into a long peaceful sleep. 5 references.

F. A. M.

ROVENSTINE, E. A., AND PAPPER, E. M.: *Graduate Education in Anesthesiology*. J. A. M. A. 134: 1279-1283 (Aug. 16) 1947.

"The serious study of teaching philosophies and technics in anesthesiology as well as in other intellectual disciplines necessitates an appraisal of past methods, a critical evaluation of present habits and an imagination which can anticipate the needs of the future. . . . In the earliest days of anesthesia the art of administering ether, chloroform and nitrous oxide was considered knowledge that was a mysterious property of the possessor and, of course, teaching was non-existent. Gradually the concept that the management of anesthetic drugs was