

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