

To meet the emergency, instructional plans were instituted in various military hospitals and in several universities and medical centers. Medical officers were assigned as students for periods ranging from several weeks to months. . . .

"There is little doubt, however, that the interest in anesthesia developed in many of these students and their surgical confrères if one can judge by the rather large number of veterans who have sought more thorough instruction in anesthesia after discharge from the services. . . . In the postwar period the teaching of anesthesiology requires enormous versatility because of the manifold and divergent problems which are unsolved. . . . Of necessity, the colleges of medicine and other teaching medical institutions will not have fulfilled their responsibilities completely until satisfactory teaching activities are established for anesthesiology, and other specialties in which the demand overwhelms the possible supply. This situation will exist for the foreseeable professional lifetime of most of us. . . . It is in institutions of the university classification that adequate library possibilities, abundant clinical material, opportunity for laboratory experience and the academic atmosphere may be collected for the benefit of the student. It is the obligation of these institutions to provide graduate education in anesthesiology." 1 reference.

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SAHER, N. F.: *Curare in Anaesthesia*. Indian J. Surg. 8: 178-180 (Dec.) 1946.

When one single anesthetic agent is "pushed" to near-lethal doses, in an effort to produce adequate abdominal relaxation, the patient pays in terms of toxicity in the post-operative and convalescent period. Ether, pentothal, cyclopropane and spinal analgesia, each has its limitations in producing

relaxation for intra-abdominal operations. The combination of regional anesthesia with light, general anesthesia, although satisfactory for providing relaxation, is time-consuming and not without toxic effects.

Curare, one of the oldest known poisons, is not an anesthetic. It paralyzes skeletal muscles by blocking the nerve impulses at the myoneural junction. The diaphragm is the last muscle paralyzed. Clinical doses do not affect the cardiac and involuntary musculature. Curare is partly destroyed in the liver and partly excreted unchanged by the kidneys.

The recognized signs of general anesthesia disappear when curare is administered. Intocostrin was used in a series of 35 cases in conjunction with cyclopropane or ether anesthesia. The average dose of intocostrin was about 60 mgm. Smaller doses were used when ether was given than were necessary when cyclopropane was used. The dose was varied according to the build, general condition and size of the patient as well as the anesthetic agent and the depth of anesthesia. Transient respiratory depression, when it occurred, was taken care of by "assisted" or "controlled" respiration. The average duration of relaxation was twenty to forty-five minutes. For gastric and upper abdominal surgery and in cases of intestinal obstruction, a cuffed orotracheal tube was used. In other cases a Waters' airway or no artificial airway was used.

Curare is not a drug for the inexperienced nor is it a cure for inefficiently administered anesthetics. Myasthenia gravis or the inability of the anesthetist to take care of respiratory depression are the two contraindications to the use of curare. The general well being of the patients who received curare with prolonged anesthesia for abdominal surgery has been pleasantly surprising. 12 references.

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