from a sphygmomanometer is connected to a suitable length of wide bore intravenous tubing (3/16 inch I.D.), over the far end of which a piece of latex Penrose tubing, size 5/8 inch is fastened by a tightly wound elastic band. The Penrose tubing is just long enough to pass through the two holes in the box and underlie the bottle. The far end of the Penrose tubing is similarly fastened by an elastic band over another much shorter piece of the intravenous tube. When the apparatus is in use, a screw clamp is tightened over the short end piece of intravenous tubing sufficiently to close it, and the valve on the hand bulb is left open. Squeezing the hand bulb rhythmically will rhythmically inflate the Penrose tubing. If the ends of the intravenous tubes nearest the box are fastened down by pieces of wide elastic stretched over them and tacked to the base board on which the box rests, this will prevent pulling through and twisting of the Penrose tubing, and subsequent ballooning.

This simple apparatus will permit the blood drawer to take several donors with little or no help.

SAMUEL WOLFSON, M.D.,
New Britain General Hospital,
New Britain, Conn.

CORRESPONDENCE

Dear Dr. Torell:

I must apologise for the delay in the writing of this letter, which I promised to send you when I wrote in mid-October, but much has happened since then to prevent me giving adequate time and thought to it. I do not know how full an account of the centenary celebrations over here you have received, but we have heard comparatively little as yet of your own celebrations at Boston, among other places.

In mid-October, Lord Moran opened an exhibition of old anaesthetic apparatus in the Wellcome Museum and Dr. Ashworth Underwood set the fox among the chickens by his announcement of his discovery of a much earlier ether administration than had been suspected, in this country at any rate. Unfortunately, I was unable to be present then as my duties kept me here. However, the Committee was good enough to give a ten-day holiday at the end of October including the time of the celebrations. They opened with the reception by the President, Sir Alfred Webb-Johnson, at the Royal College of Surgeons. We all gathered in the lecture room to await the arrival of the Princess Royal, who was to unveil a memorial tablet in the main hall of the College. Prior to the unveiling, Dr. Marston, who is the President of the Association of Anaesthetists, gave a short speech outlining the work and careers of the four pioneers commemorated on the tablet, Henry Hickman, John Snow, James Young Simpson and Joseph Thomas Clover. He succeeded in bringing more than the suggestion of a smile to Her Royal Highness's face on several occasions, which is quite an achievement. His speech was all that it ought to have been, a masterpiece of brevity yet containing much information and an admirable introduction to the actual unveiling. It was really a very colourful scene, with all the women in evening gowns and the men wearing academic dress, which for many of them is a brilliant red gown, sometimes edged with mauve and for the Presidents of the Royal Colleges much in the way of gold facings.

After a short interval in which we moved out into the main hall, Her Royal Highness unveiled the tablet following a short speech in which she paid tribute to our work and that of all those who have gone before us. It is a plain tablet bearing the arms of the Royal College of Surgeons and the Association of Anaesthetists at the head and a short paragraph above the names of those commemorated. Following this we all moved up to the Library for refreshments and to study the exhibition of apparatus arranged by the various firms concerned with the manufacture of apparatus and anaesthetic drugs, all of whom had their representatives there to answer questions.

The next morning demonstrations were being given at various of the big teaching

hospitals and I attended that at the Westminster, where Dr. Geoffrey Organe, one of our more brilliant younger anaesthetists, was showing two types of anaesthesia for partial gastrectomy. The first patient, a healthy male of about thirty-five, apart from his ulcer, received half a gramme of pentothal followed by nitrous oxide and oxygen, while a posterior intercostal block was performed. He was kept asleep with gas and oxygen throughout the operation, thus avoiding the necessity of performing a splanchnic block. The latter appears to be in disfavour among reputable anaesthetists here, as they feel that it causes a fall in blood pressure comparable to that produced by a high spinal anaesthetic. For that reason they would rather keep their patient just asleep allowing the surgeon to infiltrate the region round the esophageal hiatus if necessary. Certainly the blood pressure chart which was kept in this case was entirely satisfactory, as were the majority of those that Dr. Organe showed us later.

The second case was very similar but this time he received half a gramme of pentothal and fifteen milligrammes of d-tubocurarine chloride, followed by nitrous oxide and oxygen. Shortly after opening the peritoneum relaxation was not entirely satisfactory and the patient appeared to be rather light, so a further five milligrammes of tubocurarine was given. It has been found here that if the patient becomes apparently light, additions of either more pentothal or more tubocurarine will suffice to carry him on. When the time came to close up he had tightened up again, so rather than give more tubocurarine it was an easy matter to give a little ether as his larynx was still sufficiently relaxed not to go into spasm when suddenly assaulted by ether vapour. Once again the blood pressure chart was entirely satisfactory and the patient practically awake on his return to the ward. It was most helpful to me to be able to see these things being done by someone else and to be able to ask questions about them.

The afternoon was occupied with the Annual General Meeting of the Association of Anaesthetists. Some of the outstanding events of the afternoon were the presentation of the John Snow Medal, for the first time, to its first three recipients, Lt. Col. Featherstone, Maj. Morrison, and Squadron-Leader Pask, all of whom have contributed nobly to our art or standing during the war years. The first named has, of course, been a prominent figure among us for many years and this was an official recognition of all that he has done for us. The President was also presented with a chain of office, and in view of all the work he has put in on our behalf during the past eighteen months we were glad that he would be the first to wear it.

In the evening there was a grand dinner in the Bencher's Hall of Lincoln's Inn followed by speeches by all and sundry, most of them saying what was expected of them. We were very glad to welcome Wesley Bourne among us, and I was especially pleased to meet him as he was one of the great names in the physiology of anaesthesia on whom I had been brought up.

I met him again the following morning at a demonstration by Ronald Jarman at the Royal Cancer Hospital. He (Jarman) did much of the original work to popularise pentothal over here and was another person I was glad to have the opportunity of meeting. He showed us the method of anaesthesia they use for an abdomino-perineal resection of the rectum, which consists of half a gramme of pentothal followed by a spinal anaesthetic using a light solution of nupercaine, given by the Etherington-Wilson method, and then continuing with nitrous oxide and oxygen. I must admit that though the patient's condition at the end seemed excellent (they always receive a pint of blood on return to the ward) she seemed to be receiving a very low percentage of oxygen throughout (a McKesson was the machine used to deliver it). Dr. Jarman was also able to show us some of his recent successes, including an oesophago-gastrectomy for a growth at the lower end of the oesophagus, with an oesophago-jejunal anastomosis performed through the left pleural cavity. For this he had used pentothal and curare with some cyclopropane toward the end. The man seemed to be doing very well though they had only just taken him off his intravenous drip. He also showed us a woman who had had a resection of the lower end of her oesophagus and cardiac

end of her stomach for an achalasia of the cardia under a similar anaesthetic. She had done extremely well and had never given them a moments trouble.

After lunch at the hospital, we proceeded to the inaugural meeting of the Group of Anaesthetists at the British Medical Association building. This Group has been formed to foster the interests of anaesthetists within the B.M.A. It was not without its excitements, for one of the more ardently anti-Government members put before us a resolution which was so worded that it entrapped many into voting for it who would not have otherwise done so. This meant that later we had to go back and rescind it and pass a more mildly worded alternative. We finally ended by dumping all remaining business in the lap of a committee yet to be elected.

The final item in our celebrations was a reception that evening by the immediate Past-President of the Royal Society of Medicine, Sir Gordon-Taylor and Dr. Stanley Rowbotham, President of the Anaesthetic Section at the Society's House. Following a buffet supper, Dr. Rowbotham delivered his Presidential address on A Hundred Years of Anaesthesia. This was an interesting account of the way our specialty has developed more especially in this country. Sir Gordon preceded the address with a short speech of welcome. Dr. Magill, well known in your country, I think, proposed the vote of thanks at the end.

And so we celebrated the centenary of anaesthesia over here. I should be very glad to hear more of the celebrations in your country.

I have much to keep me busy here now and am using more curare as supplies are now more easily available, while trying to develop my own technique for using local anaesthesia. And here I must stop, with apologies for my bad typing and hoping that you will not find this letter too tedious.

Yours very sincerely,

(signed) RANALD J. M. STEVEN,
Resident Anaesthetist,
The Royal Infirmary,
Bradford, England

Dear Dr. Tovell:

Thank you for your letter of February 3rd, last. I am honoured by your desire to submit my letter to the Editor of ANESTHESIOLOGY for publication, and willingly give permission for you to do so.

I would like though to try and give you a few more details of the Annual Meeting and of the Dinner. At the Annual Meeting we welcomed the appearance of the new Journal *"Anaesthesia"* which is being published by the Association. Its first number had appeared at the beginning of October and we expect great things of it.

And here are some further notes on the recipients of the John Snow Medal.

Lt. Col. H. W. Featherstone, O.B.E., was presented to the meeting as the first recipient by Dr. W. A. Low, who paid tribute to the work he had done on a hospital ship early in the war until ill-health forced him to leave the Army, when he threw himself into the organization of the war-time medical services. Apart from that he has been a prominent figure in the development of anaesthesia as a specialty demanding special experience and qualifications, and was instrumental in setting up, or at least in persuading the Royal Colleges to create a Diploma in Anaesthetics, with regular examinations for candidates for this Diploma.

Major L. G. Morrison, M.C., was presented in his absence by Dr. Geoffrey Organe. He spoke of his bravery which had earned him his Military Cross, on the Anzio beachhead, if I remember correctly.

Squadron-Leader C. A. Pask, O.B.E., was presented by Dr. Freda Bannister. She has been associated with him in many of the hazardous experiments in which he took part during the War. On one occasion he allowed himself to be anaesthetised to the point of cessation of respiration when he was intubated and various methods of artificial respiration tried on him to see which was the most efficient. On another occasion he was anaesthetised, and wearing the various life-preservers in current use (Mae-Wests), was thrown into a swimming-bath to see if they were effective in keeping an unconscious subject's face above the water. On one occasion during