FIG. 3. "Reservoir bag added."

per cent of the tonsillectomies and adenoidectomies done in this hospital are accomplished with the arrangement shown in figure 1. It is efficient enough to maintain anesthesia in adults, especially when oxygen is bubbled into the ether. An infant 6 days old was safely anesthetized for a two-hour facial operation with the apparatus shown in figure 3.

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CORRESPONDENCE

To the Editor:

On page 38 of the January 1947 issue of ANESTHESIOLOGY Drs. Burstein and Alexander explained their technic for induction and intubation with 4 per cent sodium pentothal for thoracic surgery. They did not mention disturbances in cardiac rhythm that follow immediate intubation.

On page 529 in the September 1947 issue of the same journal Dr. Draper et al. mentioned the fact that "occasional disturbances in cardiac rhythm appeared to be the result of the rapid injection of the large initial dose of pentothal sodium required to produce and maintain respiratory arrest." The authority for this statement is the work of Kohn and Lederer in their studies on pentothal, with special

references to the electrocardiogram. This was published in the J. Lab. & Clin. Med. in April 1938.

During the past few months I tried Drs. Burstein and Alexander's method on about a dozen patients and have given it up because I encountered cardiac irregularities immediately following intubation. These did not disappear until the patients were well saturated with ether. I agree with Drs. Burstein and Alexander that the method is rapid and pleasant.

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To the Editor:

While reading Dr. S. C. Cullen's article published in Vol. 8 of ANESTHESIOLOGY (Sept.) 1947, under the editorial heading, I remembered the similar medical mission sponsored by the UNITARIAN SERVICE COMMITTEE with UNNRA assistance, which had the task of visiting Czechoslovakia during the summer 1946, and especially Dr. Rovenstine's visit.

My letter is closely concerned with the problems of anesthesia in Czechoslovakia. Before the second World War, as in many other parts of the European Continent, the dominating method was local infiltration anesthesia introduced by the German scientist, K. L. Schleich. The choice of cases has been often very liberal, ranging from trivial operations to thoracic or high abdominal cases.

Spinal anesthesia, which was actually introduced in Europe by the German surgeon A. Bier, has found a limited field among a small group of admirers. The clinical use of spinal anesthesia has been little changed, persisting in the original technic of the sit-up position and administration of hyperbaric solutions (mainly Stovaine or locally produced novocaine solutions under various tradenames). There were even more antagonists who had expressed their aversion for the above method, basing their experience on a couple of misadventures due presumably to wrongly chosen cases.

Both local infiltration and spinal anesthesia have always been carried out by the surgeon himself taking over the responsibility for the surgical and anesthetic care of the patient. There was seldom someone watching the patient's respiration, controlling cardiovascular changes, a.s.o.

I am stressing this particular point to illustrate the surgeons' conception, which still exists, that the patient's condition and treatment is the responsibility of one person only, including the preoperative, operative or postoperative care, supportive therapy, etc.

Intravenous anesthesia, which was introduced five or six years before the war using the German product Evipan, has been mostly applied for short procedures, namely in gynecology.

Inhalation anesthesia has been in the most lamentable situation. Apart from open ether-drop technic with the Schimmelbusch facepiece, there has been a slight improvement in addition to the equipment of the Ombredane apparatus, which is actually an improvised copy of the English Clover apparatus. The only suitable equipment for the insufflation anesthesia and anesthesia under positive pressure consisted of a bulky apparatus known as the Roth-Draeger.

This country gave us the famous surgeon Prof. K. Maydl who at the end of the last century showed a great interest in the line of anesthesia. Being aware of the wide sequelae caused by the known methods of anesthesia, especially in throat, mouth and facial surgery, and studying O'Dwyers intubation technic, he made the first attempt to give a firm base to intratracheal intubation. His brilliant success, chiefly in otorhinolaryngologic operations, proved that his technic was a sound method in clinical anesthesia. Unfortunately, there was nobody, after his death, to continue the study of this problem.

The attitude of the surgeons gave very little encouragement to young doctors to qualify in anesthesia, as it was not regarded as a special branch. It even happened that sometimes, before this war, a scholarship offered in this country to young doctors to go to the States to train in anesthesia had to be given up on account of lack of candidates.

With such an outlook in anesthesia, and