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

particularly in inhalation anesthesia, it is easy to see that the choice of methods and agents depended entirely on the surgeon himself, and it was no wonder that they were often selected empirically. It was no exception that the administration was also entrusted to laymen.

There was just a small number of us returning home after this war who had gained experience in anesthesia. Most of them were members of the Czech Army, some of them holding appointments in the British Army or single cases of younger and older colleagues holding appointments during the war in British civilian hospitals. Some of the colleagues came in accidental touch with U. S. Army Medical Units. Among them only scanty exceptions belong to the medical profession who took the trouble to become graded anesthetists. To those, in fact, should be paid the tribute that they took up the immense task of propagating knowledge of the effectiveness and great importance of the modern anesthetic practices, and the need for improving the state of anesthesiology and the scope of the specialty.

Before even the visit of the U. S. medical mission to this country some initiative steps were taken to demonstrate films in anesthesia for various medical schools. I should like to mention here in the first place the Prague British Council, to whom we are greatly indebted for the useful help in lending us these valuable films. The Czech Ministry of Health has been responsible for devoting its time to two conferences on the special problems of anesthesia. It succeeded at least in a few very essential matters, e.g., that the production of nitrous oxide has been started, although on a provisional scale, and that special training in the Western countries of new adepts in anesthesia is at the present time unquestionably assisted.

There are several points in Dr. Cullen's article to be sincerely appreciated. They are his strong recommendations to support these pioneers of anesthesia in the European countries impoverished by the war, his appeal to scientific or philanthropic groups who could contemplate supplying of necessary equipment to bring the whole matter to a concrete and proper solution and, of course, finding a way to enable the medical profession in Europe to receive a special training in anesthesia in the appropriate schools of the U. S.

I could feel how many of us appreciate Dr. E. A. Rovenstine's efforts in his (there were 69) brilliant lectures on anesthesia or practical demonstrations on cases operated on by other members of the same mission. The same thanks belongs to Dr. F. R. Gusterson, a member of the British medical mission which visited Czechoslovakia this summer, who has also devoted his time in learning to understand our troublesome problems.

To those who gave up their precious time during this war in instructing and training us European pioneers in anesthesia, I am dedicating this remembrance; especially I should like personally to address my expression of gratitude to Dr. F. Bannister and Dr. St. Rowbotham. I owe also my deepest personal acknowledgment to Dr. J. Lundy, Dr. K. H. Beecher, Dr. N. A. Gillespie, Dr. Harold Griffith of Montreal, Dr. S. Cullen and Dr. Ruth C. Martin who have found full understanding of our uneasy tasks and for providing us with necessary and badly needed literary sources.

Please accept my many thanks in submitting this letter.

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To the Editor:

When I started to administer the anesthetic agent (ether) at 11:49 p.m. the age of the patient was exactly 2 hours and 39 minutes. The operation which lasted from 12:02 a.m. November 10, 1947, to 12:43, was for repair of a very severe umbilical hernia which was growing larger every minute and would probably have resulted in strangulation. The hernia was repaired and a Meckel's diverticulum removed by W. M. Falor, M.D.

The patient "came through" in good condition. The case is reported because his