proved, through the years, to be a safe, nontoxic and dependable method of preparing a patient for surgery in cases in which it is indicated. . . . Although many surgeons today are utilizing the benefits offered by this form of anesthesia, there are still too many who refuse to accept its advantages and in doing so deny their patients the indicated anesthetic in many instances."

J. C. M. C.

FINK, A. I.: *Changes in the Angioscotomas Associated with the Oral Administration of Evipal.* Association for Research in Ophthalmology. Proceedings. **15**: 35–39 (July 2) 1946.

"For some time ophthalmologists have been concerned with the question as to whether barbiturates are contraindicated in the treatment of patients with glaucoma. This concern has derived to a great extent from the fact that large doses of barbiturates have been known to produce a dilation and to increase the permeability of the cerebral blood vessels and capillary bed. With a suitable method, one could study the effect of an orally administered barbiturate upon the retinal vascular system. Angioscotometry was chosen as a suitable method for this experiment, since changes in the normal angioscotoma are assumed to represent alterations in the functions of the retinal perivascular space. . . . Ten studies were carried out on 10 different subjects, 9 female and 1 male. The ages of the subjects ranged from 21 to 26 years. All known causes for alteration of the angioscotoma were carefully eliminated. Each subject was found to be in good health. . . .

"The oral administration of 4 gr. of evipal was associated with a widening of the angioscotoma in 8 of 10 subjects. The other two showed no recognizable change. Administration of a placebo containing 4 gr. of lactose to 5 of the subjects of the evipal series produced no alteration of the angioscotoma. One might ascribe the associated effect of evipal on the normal angioscotoma as related to changes in: (a) the perivascular space functions; (b) conductivity of the retinal neurons and synaptic junctions; and (c) the parasympathetic nervous system." 8 references.

J. C. M. C.

FREEMAN, L. W., AND HEIMBURGER, R. F.: *Surgical Relief of Pain in Paraplegic Patients.* Arch. Surg. **55**: 433–440 (Oct.) 1947.

"Recent years have brought the wholesale discard of older concepts of paraplegic care, and the life expectancy of the average patient with severe injury of the spinal cord has been lengthened from about eighteen months to perhaps a normal one. . . . For the purposes of simplification, pain in the paraplegic patient can be classified into three types. . . . Somatic pain is that pain characterized by intermittency, sharpness and conformation to dermatome patterns. It is found most frequently in patients with injury to the cauda equina and affects the dermatomes in which no sensation is present. Thus it can be likened to a phantom pain. In some instances the hyperalgesia of the segments lying directly above the site of injury may amount to actual pain. . . . Sympathetic pain is characterized by its constancy, by its dull, aching or burning nature and by its vague reference to such regions as the back of the leg. This includes the so-called visceral pain. . . . Psychic pain has no definite characterizing features and does not lend itself to definition. . . . When the psychic component must be considered as a large contributor, a course of placebo therapy will often be of considerable benefit. In highly emotional patients the threat of suicide during such a course has

been encountered. . . . Sympathetic nerve block . . . should temporarily relieve the sympathetic type of pain. However, since the origin of the pain is probably not peripheral, care should be exercised in evaluating therapy suggested by this procedure. Procaine hydrochloride anesthesia of 'trigger points' . . . should be used in all cases in which they . . . can be demonstrated. Caudal or extradural procaine hydrochloride anesthesia . . . will temporarily relieve somatic pain but often will not influence psychic pain. Controlled spinal anesthesia . . . has been used in a modified fashion to demonstrate the likelihood of success of intraspinal procedures. Each of these test methods may give permanent benefits, especially if they are repeated. . . . Bilateral chordotomy performed high up, below the arm area, is presented as the best answer to the problem of somatic and sympathetic pain in the trunk and lower limbs of patients with injury of the spinal cord." 9 references.

J. C. M. C.

GRANT-WHYTE, H. G.: *Diploma in Anaesthesia.* South African M. J. 21: 234–235 (Apr. 12) 1947.

"The Medical and Dental Education Committee of the South African Medical Council has accepted by a large majority, according to the Star, Johannesburg, of 13th March, 1947, the amendment of Prof. Middleton-Shaw that the Diploma in Anaesthesia to be instituted at the Witwatersrand University be available to both Dental and Medical graduates and be regarded as an additional qualification. This resolution was passed despite the views of the Medical Association of South Africa, expressed through its Federal Council, and the South African Society of Anaesthetists, whose prime object is to promote the development and the study of anaesthetics and their administration, and the recognition of anaesthesia as a specialized branch of medicine. . . . Unfortunately, probably no other field of medical practice is less well understood than anaesthesia, and this lack of understanding of the importance of modern anaesthesia is so widespread among the profession and lay public that it constitutes a serious hazard to the advancement of the specialty. . . .

"Prof. Shaw is reported, inter alia, to have said that there is no difference between dental and medical anaesthesia, that dentists were trained to give anaesthetics during the war, and that because they received the same training in the basic sciences, there really was no valid argument against giving the dentists the same facilities for obtaining the Diploma in Anaesthesia as would be given to medical graduates. . . . If then a diploma is instituted, let it be the 'hallmark' of a trained anaesthetist and not merely a certificate held by an anaesthetic technician. . . . The Medical Association has given its views, as has the South African Society of Anaesthetists—the latter not with a view to keeping anaesthesia a close preserve for doctors and anaesthetic specialists, but because of its anxiety to provide a good anaesthetic service for the peoples of South Africa."

J. C. M. C.

GRANT-WHYTE, H.; WERE, G.; DUNCAN, J.; BAM, J.; JONES, C. S.; PARK-ROSS, M., AND BRONTE-STEWART, B.: *Annual Report, Department of Anaesthesia, Addington Hospital, Durban, 1946.* South African Med. J. 21: 522–526 (July 26) 1947.

"This report covers the period from January 1, 1946, to December 31, 1946, and is the second Annual Report issued from this Department. During the year an Assistant Honorary Anaesthetist and a Registrar joined the Department, and there were some unset-