discover not only chloroform anaesthesia but an anaesthetic method. Anaesthesia became a science under Simpson's guidance. . . . Born at Bathgate, Linlithgowshire, in 1811, James Simpson was the son of a baker. . . . The family resolved that Jamie should have a good education. . . . An incident of his student days turned his attention to anaesthesia: it was during his attendance at an operation—and very little imagination is required to enable one to picture the horrors of surgery without anaesthesia and the agony endured by the central figure on the table. James Simpson's whole soul revolted at the sight as he left the Infirmary and sped towards Parliament House, resolved to exchange the profession of medicine for that of law. Success would have followed him there, or indeed anywhere. On second thoughts, however, he determined that he would try to relieve pain instead of running away from it. The opportunity was soon to come. It was John Thomson, the professor of pathology, whom he assisted; who suggested to Simpson that he might do well to specialize in obstetrics. . . .

"A few years later the chair of midwifery fell vacant. Simpson had set his heart on it, and he was well prepared. Many thought him too young, and on hearing this he determined that he would indeed be young. On an impulse he sat down and signed his application James Young Simpson. Appointed to the chair by the majority of a single vote, he now entered upon his duties with characteristic energy and enthusiasm. . . . When the news of the American discovery reached him, he told his brother that it was a 'glorious thought' and that he 'could think of naught else.' In January, 1847, he was the first to use ether in obstetric practice. . . . Dr. David Waldie, a Linlithgow lad who had become a chemist in Liverpool, thought that chloroform might be worth trying, and Simpson acknowledged this hint and acted upon it. . . .

"Simpson never claimed to have discovered chloroform, nor did he claim to be the first to use general anaesthesia. The substance chloroform was first produced about 1831 by Guthrie in America, Soubeiran in France, and Liebig in Germany, each chemist working independently of the others. . . . Simpson was, however, the first to demonstrate the anaesthetic properties of chloroform. . . . Lister wrote a most valuable paper on chloroform anaesthesia. . . . Lister's paper appeared in 1861. . . . Among those who promoted the safety of chloroform administration by new dosimetric methods was John Snow."

J. C. M. C.

HALL, J. E.: *Demerol for Analgesia in Obstetrics.* Brooklyn Hosp. J. **5**: 45–48 (Jan.) 1947.

"Demerol . . . produces both morphine-like and atropine-like effects upon the human. It has been used successfully in the Department of Obstetrics of Harvard Medical School and in the Boston Lying-in Hospital. The good results obtained in these institutions prompted the use of demerol in the author's private obstetrical cases at The Brooklyn Hospital. This report covers a period of nine months during which this drug was employed in 125 unselected and consecutive obstetrical cases. The number of primiparae and multiparae was about equal; there were 61 of the former and 64 of the latter. . . . The usual dose of demerol administered was 100 mg. given intramuscularly in conjunction with 0.00032 Gm. of scopolamine. . . .

"When the medication was given in proper amounts, satisfactory analgesia was obtained with practically no ill effects on the mothers. There was less depression of the babies' respiratory

systems than when morphine was employed. By the use of demerol and scopolamine, a sufficient degree of analgesia was produced to permit the use of local anesthesia for delivery in 48 per cent of the entire series, and in 83 per cent of the last 56 cases. The only cases in this series in which local anesthesia could not be employed were those in which delivery was difficult. The patients occasionally encountered who become irrational following the use of analgesics cannot, of course, be delivered under local anesthesia. By making it possible to deliver most patients under local anesthesia, the use of demerol tends to remove several hazards incident to inhalation anesthesia and thus increases the safety of modern obstetrics." 2 references.

HAYWARD-BUTT, J. T., AND CAMP, B. A.: *Trilene Analgesia—Simple Apparatus for Self-Administration.* Lancet. **2**: 865–867 (Dec. 13) 1947.

"During the late war there was a great demand for a rapid and safe analgesic capable of use with no more that printed instructions. Early experience with assault landing troops showed that a satisfactory, though short, analgesia could be induced with a wool plug soaked in "Trilene" in an ordinary "Benzedrine" nasal inhaler. From these observations . . . an instrument was gradually evolved for the use of commandos, air, naval, and tank crews, and ambulance personnel, as well as to meet most of the normal medical requirements of trilene analgesia. . . . The inhaler . . . is of metal, 8¼ inches long and ⅞ inch in diameter, and weights 10 oz. when fully loaded. It is designed on the principle of a cigarette lighter with an absorbent cotton-wool pad and a capillary wick leading trilene from a 6 ml. ampoule into a vaporising chamber seated in a nasal nozzle. This volume of trilene is just enough to saturate the pad without producing any fluid excess, and though sufficient for analgesia lasting sixty to ninety minutes is insufficient to produce anaesthesia. The inhaler is brought into use by breaking the base of the ampoule with a spring plunger. . . . The inhaler is used in a similar way to the familiar nasal inhalers, and, if the patient is told this, it will be correctly used at once. . . .

"It has been tested by 37 of my colleagues in 1183 cases comprising 67 different painful conditions. Analgesia was 'good' in 85 per cent of cases, 'fair' in 9 per cent and in 6 per cent failed to develop at all. This efficiency is equal to that attained with larger and more complex machines." 4 references.

J. C. M. C.

KATZ, R. A.: *Diethyl Oxide: New Therapy in Impending Gangrene.* Clin. Med. **54**: 92–94 (Mar.) 1947.

"Therapy in arteriosclerosis and associated ischemic states has reached a terrifying low stage in medical interest, and this in the face of statistics which point to diseases of the blood vessels as being the greatest single cause of morbidity and mortality in America. . . . A preliminary report after nearly two years study on the effect of diethyl oxide (U.S.P. diethyl ether) in the therapy of ischemic states has been presented for clinical evaluation by the profession. The term diethyl oxide is used because of the adverse psychological effect in patients when the term 'ether' is used. . . . Both the diethyl ether (anaesthetic ether) and the dilution media should be refrigerated before being mixed. After adding the ether, the solution should be shaken. It is important to surround the infusion bottle with two ice bags. This is important since the vapor pressure of the ether rises rapidly in a warm environment and hence will leave the solution, thereby doing very little good.