as this. The usual limits set are dizziness or drowsiness. The rapid and flexible control of administration permits of this fine adjustment and its maintenance for long periods. . . .

"There is an absence of pain. This remains relieved in an effective, safe and prolonged manner. Screaming and crying are absent at any stage and the patients are comfortable throughout and recover completely soon after the cessation of the infusion. Nausea, headache and other sequelae are absent and the mother, apart from an occasional elevation of the blood pressure or pulse rate, shows no evidence immediately after the birth of having had an analgesic administered. . . . There is no effect on the child. . . . Consciousness is retained. . . . The absence of a desire or urge to bear down or exert voluntary expulsive effort has been repeatedly noted. . . . I am of the opinion that in cautious hands the risk of convulsions is a minor hazard which is easily combated by watchfulness, care and attention to technic. . . . The only disadvantage so far encountered with intravenous analgesia is the necessity of constant supervision." . . . 28 references.

J. C. M. C.

SEGAL, BLUMY: *The "Open" Endotracheal Method of Anaesthesia for Harelip and Cleft Palate Operations on Infants.* South African M. J. 21: 484–485 (July 12) 1947.

"The 'open' endotracheal method of anaesthesia, also known as Ayer's technic, for the repair of harelip and cleft palate, has proved decidedly advantageous to the little patient, greatly contributed to the peace of mind of the anaesthetist, and in no small measure eased the task of the surgeon. . . . Before the patient is anaesthetised a tube should be roughly measured by placing it alongside the child's neck and ascertaining that its length, measured from the mouth in orotracheal and from the nares in nasotracheal intubation, will not extend beyond the level of the second costal cartilage. A mark is made on the tube with methylene blue. The average length is 3½ to 4 inches. The infant is now induced with a very small amount of ethyl chloride followed by 'open' ether. Induction is very slow and oxygen is administered all the time. By passing a small tube into the pharynx via the nose and delivering oxygen and ether vapour, the anaesthesia is easier maintained whilst the laryngoscope is used, for intubation. The small blade of this instrument is lubricated with sterile liquid paraffin. An attempt is first made with the largest of the endotracheal tubes; if that fails, the next size is used. . . .

"For harelip operations the tube is passed through the mouth and placed in the corner of the mouth opposite the cleft, for the cleft palate via the nose. . . . The small end of the metal angle piece is attached to the endotracheal tube and the wide distal end is connected by means of a 1 inch length of rubber tubing to one of the large open ends of the Ayre's T-piece. To the other open end of the Ayre's T-piece is attached a rubber tube 7 inches long and 11 to 13 mm. in diameter. The smaller the infant, the shorter the tube. . . . A small wisp of cotton-wool is attached to the end of this tube by adhesive tape. . . . The complete Ayre apparatus rests on a sandbag placed at the side of the head, preventing any side traction on the endotracheal tube. The inlet portion of the T-piece is attached to a Boyle's machine (the rebreathing bag and expiratory valve not being employed) or any apparatus delivering a continuous flow of oxygen and ether vapour. The flow of the oxygen is regulated at the rate of 1½ to 2 litres per minute. . . . Before the endotracheal

tube is removed suction is applied to remove any blood which may have accidentally seeped into the trachea, larynx and pharynx. Immediately prior to removal of child to ward, a stitch is passed through the tongue in order to prevent the tongue falling back." 3 references.

J. C. M. C.

SELTZER, A. P.: *Conduction Anesthesia for Focal Neuralgias in Rhinologic Practice.* Am. Practitioner. **1**: 671–674 (Aug.) 1947.

"The frequency with which patients with facial neuralgias appear for relief in the office of the rhinologist indicates the importance of the question to the practitioner in this field. . . . The most frequent site of pain is at the supraorbital notch. With the usual surgical preparation, the nerve is injected with 1 per cent novocaine and 1:20,000 adrenalin. This procedure gives immediate relief of the pain. The point which is second in frequency in facial pain is associated with the nasociliary nerve. The exact place for injection is at the junction of the nasal bone with the upper lateral cartilage at about the midpoint. Less frequently, pain can be relieved by injection of the sphenopalatine ganglion. The point of entrance is determined by drawing a horizontal line outward from and parallel to the lower surface of the external nose; a second line is dropped perpendicularly from the external canthus of the eye, at right angles to the first one. A needle 7 cm. long is entered at this point of junction of the two lines, and is extended backward, medially and slightly downward to reach the pterygomaxillary fossa, where 3 to 5 cc. of novocaine are injected.

"Occasionally the postauricular nerve is involved and injection is done behind the ear near the occiput. If the relief given by this treatment is only temporary, then the injections are repeated using 50 per cent alcohol, which usually gives permanent results."

J. C. M. C.

SENGER, F. L., AND ROTHFELD, S. H.: *The Effect of Caudal Anesthesia on Urinary Incontinence following Prostatectomy.* Urol. & Cutan. Rev. **51**: 497–500 (Sept.) 1947.

"One of the most distressing complications on prostatectomy is urinary incontinence. This occurs frequently enough to become a trying problem to both patient and attending surgeon. A series of such patients was given caudal anesthesia because of postoperative urinary incontinence. It was felt that lessening the tonus of the detrusor might favorably influence this symptom. . . . In 6 patients who developed urinary incontinence 30 cc. Foley catheters were used. This might be advanced as the reason for . . . incontinence; i.e. pressure upon the external sphincter. We do not believe this to be so since, in the five cases that occurred at this hospital, the Foley bags were not placed in the prostatic fossae for hemostasis but were inflated when we were certain they were in the bladder. The incontinence in all of these cases must be regarded as due to damage to the external urinary sphincter.

"It would appear that infiltration with novocaine favorably influences the urinary incontinence by diminishing the tonus of the bladder. This permits greater filling and less irritability. The urinary incontinence is not completely eliminated. However, these patients are made more comfortable; certainly the adjustment of the irritable bladder to a state approximating normal is hastened thus eliminating a long period of discomfort during the convalescence following prostatectomy. This is probably accomplished by the novocaine blocking stimuli to and