4. Practically all the albumin reactions are of no value in the routine diagnosis of pulmonary tuberculosis, (a) because the positive reaction occurs in many affections of the pulmonary tract other than tuberculosis, (b) because a negative reaction may occur in about 10 per cent. of positive pulmonary tuberculosis cases, (c) because with the test there are certain variations which would have to be eliminated in each sputum examined to permit of a reliable result, and (d) because in the case of an "inconsiderable" or "doubtful" reaction, one does not know in any given case how much importance to attach to the reaction.

DEATH FROM SPINAL ANESTHESIA

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In reporting this case I am prompted by a desire to place on record the dangerous side of this valuable method of anesthesia. It serves to illustrate the truth of the statement that there is no safe anesthetic.

On the morning of the day when the fatality occurred I had for operation two cases of fracture which required Lane plates. The first patient was a man about 40 years of age, with an oblique fracture of the tibia which would not remain in place with an ordinary splint. Morphin, 1/6 grain, and scopolamin, 1/100 grain, were administered half an hour before the operation. Stovain was injected, and satisfactory anesthesia to the middle of the abdomen quickly followed. The Lane plate was applied, the wound dressed and splinted, and the patient returned to his bed in comfort. This operation was witnessed by the physician who had brought the second patient. He had never seen spinal anesthesia used before, and remarked that it was surely an ideal anesthetic.

His patient was a woman 60 years of age with a fracture of the femur at the junction of the middle and lower third. She had received the same dose of morphin and scopolamin as the man, and at the same time, having consequently had the dose about half an hour longer. She was scarcely quieted by it, and was sensitive to movement and fully awake, exhibiting no evidence of drowsiness. The ordinary dose of stovain was injected, and anesthesia appeared almost instantly. Within two minutes her face became pale, and she ceased to breathe.

Following the suggestion of Babcock¹ I immediately commenced artificial respiration, and had it continued by the interns and assistant. The heart action continued slow, but there was no respiration. After a while I intubated the trachea with a rubber catheter, and attached an oxygen generator. Artificial respiration in addition to the oxygen was continued for one hour and fifty-five minutes, at the end of which time the patient began to breathe naturally. I am certain that had it not been for Babcock's admonition I would have abandoned the effort as hopeless before this time. The patient did not, however, become conscious after she began to breathe, and no attempt was made to plate the bone. A long splint was applied, and she was sent to bed. At the time I left the hospital about noon she was breathing regularly, her pulse slow, but there was no return of consciousness. At 4 o'clock in the afternoon I received a telephone message from the hospital that she was doing badly, and instructed the nurse to call the same interns who had done artificial respiration in the morning. Their efforts were unsuccessful, and she died within half an hour.

There are certainly some unusual features about the case, but the rapidity with which respiratory paralysis followed the stovain injection must make reasonable the presumption that the final death, though occurring nearly six hours after the stovain injection, was actually caused by it.

329 Alder Street.

1. Babcock: Surg., Gynec. and Obst., November, 1912.

New and Nonofficial Remedies

THE FOLLOWING ADDITIONAL ARTICLES HAVE BEEN ACCEPTED BY THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN Medical Association. THEIR ACCEPTANCE HAS BEEN BASED LARGELY ON EVIDENCE SUPPLIED BY THE MANUFACTURER OR HIS AGENT AND IN PART ON INVESTIGATION MADE BY OR UNDER THE DIRECTION OF THE COUNCIL. CRITICISMS AND CORRECTIONS ARE ASKED FOR TO AID IN THE REVISION OF THE MATTER BEFORE PUBLICATION IN THE BOOK "NEW AND NONOFFICIAL REMEDIES."

THE COUNCIL DESIRES PHYSICIANS TO UNDERSTAND THAT THE ACCEPTANCE OF AN ARTICLE DOES NOT NECESSARILY MEAN A RECOMMENDATION, BUT THAT, SO FAR AS KNOWN, IT COMPLIES WITH THE RULES ADOPTED BY THE COUNCIL.

W. A. PUCKNER, SECRETARY.

SODIUM GLYCEROPHOSPHATE—*Sodii Glycerophosphas*.—Sodium glycerophosphate is hydrated sodium glycerophosphate, $\text{Na}_2(\text{C}_3\text{H}_5(\text{OH})_2)_2\text{PO}_4 \cdot 5\frac{1}{2}\text{H}_2\text{O}$, the sodium salt of monoglycerophosphoric acid, $\text{H}_2(\text{C}_3\text{H}_5(\text{OH})_2)_2\text{PO}_4$, containing not less than 99 per cent. of hydrated sodium glycerophosphate.

White, monoclinic plates or scales, having a saline taste; odorless; easily soluble in cold and hot water; nearly insoluble in alcohol.

At about 60° C. (140° F.) it begins to lose its water of hydration; when strongly heated the salt yields inflammable vapors and at a red heat is converted into sodium pyrophosphate.

The aqueous solution (1 in 20) is alkaline to litmus and to phenolphthalein.

If an aqueous solution (1 in 20) be acidified with nitric acid, and an equal volume of cold ammonium molybdate solution added, it should remain clear for one hour. On heating, however, a yellow precipitate will be formed.

The aqueous solution (1 in 100) acidified with hydrochloric acid should not respond to the U. S. P. VIII time limit test for heavy metals.

The aqueous solution (1 in 100) acidified with hydrochloric acid on addition of barium chloride solution should show no distinct turbidity within one minute.

The aqueous solution (1 in 100) acidified with nitric acid should not show more than a slight opalescence with silver nitrate solution.

The aqueous solution (1 in 100) acidified with acetic acid should not become turbid within one minute on addition of ammonium oxalate test solution.

If 1 Gm. of sodium glycerophosphate be thoroughly triturated in a mortar with 20 Cc. of alcohol, the liquid filtered and the alcoholic solution evaporated spontaneously the residue, after drying over sulphuric acid, should correspond to not more than 1 per cent. of the weight of the salt taken.

If from 2 Gm. to 3 Gm. of the salt be weighed, dissolved in distilled water and the solution titrated with half-normal hydrochloric acid, using methyl orange as indicator, the acid consumed should correspond to not less than 99 per cent. of hydrated sodium glycerophosphate.

Actions and Uses.—See Calcium Glycerophosphate.

Dosage.—From 0.25 to 0.65 Gm. (4 to 10 grains) in wafers, capsules or tablets or dissolved in water or syrup. Hypodermically 0.2 to 0.25 Gm. (3 to 4 grains) in normal saline solution.

Non-Proprietary Preparation:

Sodium Glycerophosphate, Monsanto.—Manufactured by the Monsanto Chemical Works, St. Louis, Mo.

VACULES DIGITOL.—This dosage form of an accepted proprietary article has been accepted.

Each vacule contains digitol 30 Cc. in sealed ampules.

The air in the container is removed before sealing, whereby, it is claimed, deterioration of digitol is retarded.

Therapeutics

TABES DORSALIS: LOCOMOTOR ATAXIA

While there is little new in the treatment or management of this progressive disease, and while many treatments have been supposed to cause remissions in the progress of the disease, it is well to note exactly where we stand to-day in the application of therapeutic methods in the management of this chronic, painful, progressive disease of the spinal cord. Toward this end reference may be made to the article of Dr. E. L. Hunt.¹

1. Hunt, Edward L.: Am. Jour. Med. Sc., September, 1912, p. 398.