portant that haemolytic tests be made prior to transfusion.

Nitrous Oxid Oxygen Anesthesia. By T. C. Burns, Oklahoma City, Okla. Journal of the Oklahoma State Medical Association, February, 1915, pp. 284, 285.

The type of subjects best adapted for this anesthesia are men and women who are not muscular or alcoholic, children over ten years, anaemic patients and those of low vitality.

The respirations, pulse and blood pressure are about normal in nitrous oxid oxygen anesthesia, and post-operative nausea and vomiting eliminated.

In suppurative cases ether tends to destroy the phagocytic action of the blood, throwing strain on the kidneys, as we obtain anesthesia with ether by its forming a chemical compound in the blood, which require time and labor for the kidneys to eliminate. Nitrous oxid oxygen gives immediate recovery as soon as the mask is removed, as the anesthetic makes no union with the blood, thus giving no irritation to the genito-urinary tract.

We use rebreathing in this anesthesia to retain carbon dioxid, which stimulates the respiratory center, increases the absorption of nitrous oxid and maintains the carbon dioxid content of the blood, preventing acapnia.

Nitrous oxid oxygen should be given only by one trained in the work, as the patient becoming quickly cyanotic demands prompt action and experience on the part of the anesthetist. Cyanosis, under nitrous oxid, means suboxidation of the blood, not cardiac depression, and is quickly relieved by small amount of oxygen.

Advantages of nitrous oxid anesthesia are:

1. Rapid action.
2. Elimination of unpleasant sensations, and excitement stage, as in ether.
3. Rapid recovery.
4. No post-operative nausea and vomiting.
5. Absence of pneumonia, nephritis or blood changes.
6. Lack of dread for future anesthesia.

Anoci-Association in Theory and Practice. By A. B. Cooke, Los Angeles, California. Southern California Practitioner, January, 1915.

In its final analysis surgical shock is closely analagous to the conditions we know as physical fatigue and exhaustion. In fact, exhaustion of the brain cells and centers is shock. The only function, so far as we know, possessed by the brain cells connected with sensory nerve fibres is to liberate impulses which result in voluntary muscular contraction. Continuous or too often repeated functioning, as in the case of an extensive surgical operation, must ultimately mean loss of power and deterioration of the cells involved. This occurs to some extent in every surgical operation. The brain cells are in no sense protected by general anesthesia. As a matter of fact, general anesthesia accomplishes only two useful ends, namely, it produces unconsciousness and it abolishes the power of voluntary muscular action.

The only means by which the brain cells may be protected from the harmful impressions originating in the area to be traumatized is by locally anesthetizing sensory nerve endings and tracts. This is perhaps the most important of the several principles underlying the practical application of anoci-association, and the one most often to be charged with failure by those who attempt it. To accomplish its purpose the local anesthesia must be as complete and perfect as though no general anesthetic were to be employed. Failure on this score is properly chargeable to the operator, not to the method.

My personal experience with the method now embraces more than two hundred cases covering a wide range of different conditions and operations.

Penetrating Wounds of Abdomen and Thorax. By A. P. Butt, Davis, W. Va. The West Virginia Medical Journal, February, 1915, pp. 260-264.

The writer expressly omits wounds of the heart and pericardium. He admits that the subject should be obsolete. Some more or less standard methods of treatment should have been adopted years ago, but claims that such is not the case.

He believes that in the great majority of thoracic wounds expectant measures are all that are required.

The bleeding tends automatically to stop. Should it not do so Murphy's method of artificial pneumothorax should be tried.

The important thing to remember is that thoracic wounds are often abdominal also.

In wounds of the thorax the writer favors "watchful waiting." In abdominal wounds, "armed and immediate intervention."

He urges that symptoms be ignored, and that an immediate operation be performed in any case of suspected penetration.

A small incision, a slight scrutiny, the introduction of a sponge to the most dependent parts, will almost always settle the question as to whether there are wounded viscera.

Advises drainage in most cases.

Conclusion—1. Do not operate in thoracic wounds unless they are progressively getting worse. By far the most of them will recover under expectant treatment; 2. Operate all abdominal wounds.

A New Incision for Varicocele Operation When the Scrotum is to Be Amputated. By E. G. Ballenger and O. F. Elder, Atlanta, Ga. Medical Record, February 27th, 1915, p. 355.

When it is desirable to amputate the scrotum and operate for varicocele at the same time the scrotum may be drawn up so that the incision through which the varicose veins are to be removed is made through the lower part of the scrotum which is to be amputated. The scrotal clamp is then applied above the incision and the scrotum amputated as usual. In this manner the amputated part of the scrotum contains the incision made for the varicocele and saves the time required to close this wound. While the varicocele might be removed through the incision made in amputating the scrotum, this would be more complicated, much more bloody, and more likely to become infected than if performed as suggested.