

is marked by respiratory danger, the other by circulatory catastrophe. The 'sudden death' of the German writers is designated *white death*, while the less sudden fatality of primary respiratory origin is known as *blue death*.

It is probable that, in estimating the share of danger from the anæsthetic, we have to consider not only whether one or another drug is more dangerous, but whether, owing to the dyscrasia, all drugs are dangerous unless we are keenly alive to the fact that such delicate persons cannot withstand the same doses and concentrations of anæsthetics as are well within the zone of safety for the ordinary individual. It is less that the anæsthetic is dangerous, than that it is the way the anæsthetic is presented to the lymphatic patient, which courts disaster. Although chloroform is associated with a majority of these deaths, it is not proved that it is, indeed, the most perilous. It must be remembered that chloroform is the anæsthetic of choice and the one most usually employed for young persons and for operations upon the upper respiratory tract, and that it is such persons who suffer from lymphatism and usually require this type of operation. It is, however, probable that chloroform is dangerous in status lymphaticus owing to the fall of blood pressure it entails, since it is this decline in blood-pressure which is peculiarly prone to cause death in such cases. When an inexperienced anæsthetist is administering the anæsthetic, ether or an ether mixture is safer, and offers the best chance of success, but it should be given after a hypodermic injection of atropine. Death associated with lymphatism has occurred during the use of most of the general anæsthetics, and even when local analgesia has been adopted. Where chloroform is selected, it should be given in the mixture containing one volume of alcohol to nine volumes of chloroform, with high dilution of air or, better, of oxygen, and complete anæsthesia should be obtained before the operation is commenced. It adds to the patient's safety if all asphyxial complications, fear, and roughness are rigidly prevented.

*Acidosis. Post-operative Tædium. Delayed Chloroform Poisoning.*

Deaths following what appeared to have been a normal anæsthesia, obtained by chloroform, by ether, by ethyl chloride, or by a mixture of these, have been imputed to the prolonged effect of the anæsthetic upon the glandular structure of the liver and the kidneys, as well as on the muscular structure of the heart. The onset of events is marked by uncontrollable vomiting between the twelfth and forty-second hours after the inhalation: the vomit is foul and watery, greenish in colour at first, but brown later. There is marked restlessness or delirium, with intervals in which the patient is apathetic, and this apathy may end in fatal coma. The urine is scanty, and commonly contains albumin and diabetic or lactic butyric acid. The breath has the apple-like smell of acetone. The patients are usually young, commonly poorly nourished infants or children: neither the gravity of the operation nor the duration of the anæsthesia appears to count. In a large number of patients whose urine was examined before the