administration, may cause tissue-cooling, catarrh, irritation, and thrombosis after the operation. The law is certainly true that the after-effects of an anæsthetic are, in severity and frequency, a function of the amount taken. If the vapour as it enters is warmed, some of its deleterious effects are removed.

Post-operative headache, backache, vomiting, oculomotor paralysis, and paralyses of the bladder and rectum, may follow spinal analgesia. We do not know for certain whether these arise through irritation of the analgesic or through alteration in the amount of the cerebrospinal fluid. Their occurrence is rare, but at times these sequelæ are alarming. Some surgeons regard them as evidence of errors of technique; but even so it is not possible to avoid them entirely, nor should we minimize their gravity when they arise. The possibility of acute mania or delusional mania consecutive to operations undertaken under local analgesia must be remembered. Such cases are rare, and the ultimate prognosis is favourable, though the condition causes great distress to the patient's friends.

REFERENCE. Buxton, "Feed Vomiting during Anæsthesia, a Suggested Method of Obviating its Danger," *Brit. Med. Jour.* 1910, April 23.

Dudley W. Buxton.

ANEURYSM, ABDOMINAL. It is needful to remember that aneurysm of the abdominal aorta and its branches is an obscure disease, hard to detect in early stages; so that when the physician meets with a case in which there is no doubt as to the presence of an abdominal aneurysm, the sac is already large. Unhappily, the newer method of diagnosis by skiagraphy does not give as much help in the discovery of aneurysms below the diaphragm as it does in those situated within the chest. The stealthiness of the early stages of the disease is prejudicial to the patient's chance of recovery: a sac that can be felt is not likely to be 'cured.'

General Outlook. I do not know of any proved example of complete and final cure of an abdominal aneurysm large enough to be diagnosed as such. Of course there are examples of what appeared to be a pulsatile swelling connected with the abdominal aorta failing to kill the patient; but these are usually cases of atheroma, and not of real aneurysm. Again, it is not an unusual experience to encounter healed abdominal aneurysms in the course of a post-mortem examination; but these are small, as a rule, falling far short of the size which must be attained if the sac is to be detected clinically. Moreover, abdominal aneurysms are not seldom multiple; in the patient who dies from rupture of one sac, another may be found completely obliterated by lamellæ of clot. True 'cure' of abdominal aneurysm diagnosed during life is therefore almost, if not quite, unknown.

In spite of this, patients may live for a considerable time after the onset of symptoms: in one of Nunneley's series, collected from the St. George's Hospital records, the duration of the case extended over nine years; while one of the Guy's Hospital patients, whose cases were tabulated by J. H. Bryant, lasted twelve years. These are,