logic cardiorespiratory sequence. Synchronized artificial respiration associated with artificial cardiac diastole followed by artificial cardiac systole more nearly approaches this normal sequence." 7 references.

J. C. M. C.


"Many reports have recently appeared describing damage to the brain following the use of nitrous oxide anesthesia, the pathologic changes being found predominantly in the cerebral cortex and the basal ganglia. Most of the patients die during the anesthesia or a short time thereafter. Sudden death, coma, convulsions, decerebrate phenomena, delirium, paralysis, hyperthermia, visual defects, aphasia and amnesia and mental and psychic changes have been reported in various combinations, with partial or complete recovery. The appearance of a clear-cut clinical picture of extrapyramidal disease characterized mainly by choreoathetosis is rare. . . . [In one case] choreoathetosis appeared as the major symptom. . . . Our patient, fortunately, recovered, but we should like to postulate the probable location of the lesions. It would seem that the greatest damage occurred in the lenticular nucleus, but that much of this was reversible and was based on edema, which subsided. The cogwheel rigidities were due to damage of the globus pallidus. The decerebrate rigidity and the signs of involvement of the pyramidal tracts show that the long motor tracts were not spared. The definite mental and psychic changes indicate involvement of the cortex. The reason for the relative rarity of choreoathetosis would seem to be that either most patients do not survive long enough to manifest the phenomenon or that when they do the damage to the cortex and pyramidal tracts masks the extrapyramidal effects." 17 references.

J. C. M. C.


"It is common knowledge that apprehension, fear and panic are frequent accompaniments of metrazol shock therapy . . . An attempt to alleviate this resistiveness arising from severe fear reactions . . . prompted me to induce metrazol convulsions with the patient under anesthesia . . . The patient is placed in bed in the usual position of spinal hyperextension. The inhalation is begun with the Heidbrink or other suitable apparatus, using a mixture of 88 per cent nitrous oxide and 12 per cent oxygen. When the corneal reflex is lost (and this requires roughly one minute of inhalation) the needle is introduced into the patient's vein. The mask is then removed while the metrazol is injected quickly. At first it was thought advisable to open the direct flow oxygen valve of the apparatus and allow the patient two inhalations of 100 per cent oxygen just before removing the mask, but later observations have shown this to be superfluous and it has been abandoned. . . ." Three hundred and twenty-three metrazol injections were made into 40 patients under nitrous oxide anesthesia. This method was found to avoid the fear reaction so common in metrazol shock therapy without altering the convulsive pattern or the duration of the convolution. Little or no increase in the dose of metrazol was necessary to produce convulsions when the patient was under anesthesia. Traumatic complications were minimized with this method (5 per cent), and it is suggested that an-