

(4) Elevation of the foot of the bed for six to eight hours, or keeping the patients flat for twenty-four hours. In the treatment of post-spinal headache due to aseptic meningitis the administration of pitressin or glucose saline may relieve intracranial pressure by promoting diuresis. Barbiturates may be required to relieve persistent severe post-spinal headaches."

J. C. M. C.

ADLER, HARRY: *A Study of the Headaches following Diagnostic Spinal Taps*. New York State J. Med. 43: 1328-1330 (July 15) 1943.

"Our study consisted of 108 cases, and it was viewed from several aspects. We performed our spinal at 2:00 P.M., with the patient sitting erect, and did the tap as quickly as possible to avoid agitating the patient. We advised him emphatically to go to bed as late as possible; however, if the patient requested hospitalization, it was granted, and if the patient requested bed rest following the spinal, that was also granted. Since the men in our study are likely to take advantage of any opportunity to avoid work or to make known their complaints, our figures are more significant than they might be if they had been taken from a group of patients who must earn their own livelihood. Of our 108 cases, 14 had moderate or severe reactions, a percentage of 13. We thus observe that encouragement to patients to stay erect after a spinal does not increase morbidity but somewhat lowers the percentage of headaches. . . . Edematous changes have been noted in the fundi of patients who have had headaches following spinal taps. Consequently, we believe that the headaches are due to an increased amount of fluid in the central nervous system. . . . Sedation given before spinal tap entails a lower percentage of post-tap headaches. In our own series, we find a definite cor-

relation between constitutional inadequacy and headaches. We must recognize the fact that a patient lying flat on his back is bound to be very alert to any and all subjective sensations and therefore we cannot deny that putting a patient to bed after a spinal to avoid a headache is apt to encourage introspection and thereby subject the patient to many troublesome thoughts and sensations. . . . The sooner a patient goes to bed after a diagnostic spinal tap, the more apt he is to have a headache and the more likely it is to be a severe headache. The longer a patient is erect after a spinal tap, the less apt he is to have a headache, and if one is present, it is likely to be mild. We believe there are two factors that predominate as to the causative factors of spinal headaches—namely, constitutional makeup and disturbed psychogenic influences." 11 references.

J. C. M. C.

LAWRENCE, J. W.: *Barbiturate Poisoning*. J. Iowa M. Soc. 33: 303-306 (July) 1943.

"Barbiturate addiction has long been known to occur frequently and is increasing in the United States. . . . Besides the dangers of addiction, which include accidental overdosage, these drugs seem to influence many of the addicts to commit suicide. Certainly the fact that there were four cases of poisoning by the barbiturates in our 913 necropsies, which led all other poisons except alcohol as a cause of death, indicates the seriousness of their promiscuous use. . . . The following general measures should be carried out: Evacuate and wash out the stomach with permanganate solution, 1:3,000; intravenous infusions of normal saline and dextrose solutions; artificial respiration and inhalation of oxygen by nasal catheter. Strychnine may be given as a stimulant. Suction should be used for secretions which accumu-

late in the pharynx. . . . The control of barbiturate addiction largely rests with the medical profession. First, the physician should determine the cause of the insomnia and not merely treat it as a symptom, which is so often done. Second, under no circumstance should the patient be told the name of the drug being prescribed. Third, a prescription for the barbiturates should be refilled only under the same conditions which govern the refilling of prescriptions for morphine. Finally, when prescribing drugs which may be habit forming, every practitioner should bear in mind that prevention is better than cure, and, if the patient has any psychopathic stigmata, they should be prescribed only when all other methods of treatment are exhausted." 5 references.

J. C. M. C.

RAY, B. S., AND MARSHALL, V. F.: *Convulsions During General Anesthesia: Report of Twelve Cases.* Ann. Surg. 118: 130-148 (July) 1943.

"It is not often that there is justification for emphasizing a single symptom when considering the nature of a pathologic process but in the case of convulsions that occur during anesthesia there may be some excuse. A convulsion from whatever cause is always a dramatic event and when it occurs during an operation it is frequently the first and, indeed, may be the only recognized sign of what is believed to represent a serious and potentially fatal state. . . . The ages of the patients varied from two to 44 years. Three were children under seven years, and the rest were 27 years, or over. One-third were males. . . . One case occurred in March, two in April, two in June, three in August, two in September, and two in October. . . . All of our patients were operated upon in air-conditioned rooms where constant temperature and humidity were

maintained. . . . Two of the adults had had convulsions in early childhood and one was given to syncopal attacks under conditions of fatigue. . . . The diagnosis in three patients was appendicitis with peritonitis; appendicectomy and drainage were performed in each. In two patients the diagnosis was chronic cholecystitis, and in one acute cholecystitis. . . . In two patients there was disease of the common bile duct requiring tedious exploratory operation, with choledochostomy in one and repair of a stricture in the other. Two patients required pelvic operations, one for tubal pregnancy the other for an ovarian cyst, and each had had preceding uterine curettage. One patient was explored abdominally for an hypernephroma with extensive metastasis to the liver. One patient, an infant of two years, underwent a long operation and difficult anesthesia for repair of a cleft palate. . . . In our series, four of the 12 patients were acutely ill with high fever when they came to operation and, in addition, one child had not made a complete recovery from a respiratory infection. . . .

"Dehydration and acid-base imbalance, other states which so frequently accompany febrile diseases, may contribute to the initiation of convulsions by inhibiting the cells of the brain in their ability to utilize oxygen. Significance may be attached to the fact that many of the factors which have been thought to account for convulsions during anesthesia cause an increase in the H-ion concentration of blood and tissues. Deficiency in the nutritional state was present in at least three of our patients. . . . It can be postulated that heavy retraction of abdominal wound edges, trauma, excessive exposure of viscera to cooling, loss of blood and other circumstances that are ordinarily associated with shock and 'stagnant anoxia,' may be said to be conducive, as well, to the development of con-