

pears to be permanent changes in temperament and personality while another has a residual hemiparesis. . . . It has been especially illuminating to find that in four of the seven patients subjected to electro-encephalography at varying periods after their operations, there were pathologic changes recorded. It would be useful to know whether changes which may be found early after the convulsive episode would persist but our data does not supply this information. Also, it would be necessary always to take into consideration the possibility that patients may have had abnormal brain waves prior to the time of the operation. . . . The clinical evidence for damage to other organs of the body as a result of the anoxia, presumed to have caused the convulsions, is to be found in the high incidence of post-operative pulmonary complications (in seven of the ten patients who lived longer than a day after operation) and of albuminuria (in five of the ten). . . . Various blood studies made soon and late after the occurrence of convulsions in a number of the patients failed to disclose any significant changes. . . .

"When convulsions do occur it is advisable to (1) discontinue the anesthetic, (2) terminate the operation as quickly as possible; (3) administer oxygen; (4) correct any unfavorable position on the operating table; (5) keep the airway open (bronchoscopic aspiration may be required in case of atelectasis); (6) give some form of soluble barbiturate intravenously to control the convulsions, such as sodium amytal, sodium phenobarbital, or pentothal sodium; (7) replace blood or fluid loss; and (8) allay hyperthermia by sponging the body or irrigating the rectum with cold water. An oxygen tent provides the dual service of cooling and supplying adequate oxygen. There may be advantage in administering hypertonic glucose solution in-

travenously, particularly to combat un-recognized hypoglycemia and intravenous calcium gluconate or intramuscular parathormone to correct calcium imbalance." 61 references.

J. C. M.

MAHONEY, E. B., AND HOWLAND, J. W. *Treatment of the Severely Burned Patient with Special Reference to Controlled Protein Therapy.* New York State J. Med. **43**: 1307-1316 (July 15) 1943.

"The entire premise of fluid therapy depends on the daily evaluation of the patient and the replacement of plasma, whole blood, water, or electrolytes as may be required. . . . The immediate and adequate instigation of replacement therapy (fluid and protein) is the most important feature in the primary treatment of severe burns. Replacement therapy should be carefully controlled by continuous observation of plasma specific gravity (protein) and hematocrit or hemoglobin. The toxemia of burns will be minimized not entirely prevented by adequate fluid and protein replacement." 27 references.

J. C. M.

MURRAY, LT. C. K.; HALE, LT. COMMANDER, D. E., AND SHAAR, CAPT. C. M.: *The Preparation and the Use of Red Blood Cell Suspensions in Treatment of Anemia.* J. A. M. A. **122**: 1065-1067 (Aug. 14) 1943.

"The red blood cells which remain after the plasma has been aspirated by means of a closed aseptic technic are used for the preparation of the red blood cell suspension. After the plasma is removed, the aspirating needle is plunged to the bottom of the red blood cell layer and 200 cc. of cells is drawn over by means of a vacuum into a sterile 300 cc. dispensing bottle which contains 100 cc. of 5 per