per cent mortality compares favorably with the 54 per cent mortality in their previous series. The authors mention the preoperative use of sulfanilamides in patients receiving pentothal anesthesia and see no clinical contraindication to this combination of drugs. 6 references.

V. A.

CURRENS, J. H.; WHITE, P. D., AND CHURCHILL, E. D.: *Cardiac Arrhythmias following Thoracic Surgery.* New England J. Med. **229**: 360–364 (August) 1943.

Twelve cases of cardiac arrhythmia following thoracic operations are described. The cases include 8 of auricular fibrillation and 4 of auricular flutter. They occurred after pneumonectomy, lobectomy or partial esophagectomy and represent a rate of occurrence of nearly 25 per cent after such operations. With one exception the arrhythmias appeared within five days of the intervention; the other, in which auricular fibrillation occurred on the seventeenth postoperative day, responded promptly to an increase in the intrathoracic pressure from negative to positive.

Arrhythmia was transient in every case but one, and in this the auricular flutter persisted until the patient's death six months later. With this exception the disturbances of rhythm never lasted, apparently, for more than three days. It is remarked that in two cases premature auricular beats were noted before or after the tachycardia and that in four of their series there was at least one recurrence of arrhythmia following restoration of normal rhythm. In none of the cases was there any sign of cardiac failure.

Comment: In attempting to decide the cause of these arrhythmias the authors admit that it is obscure, but point out that all their patients with these disturbances had passed the age of 39, and also mention certain associations of these arrhythmias with the onset of other complications such as empyema and atelectasis. One case was found at autopsy to have a pericarditis.

In view of the frequency with which these disturbances arise, the use of quinidine as a prophylactic measure after thoracic operations may well be justified. The occurrence of auricular premature beats may give warning of the imminence of a more serious arrhythmia which quinidine might prevent. Where one of these disturbances has appeared three alternatives are at the disposal of the clinician. Since most of the patients will re-establish normal rhythm in any case no treatment may be necessary. In certain cases normal rhythm may be restored by quinidine. If cardiac failure threatens, and the arrhythmia seems to be a threat to the patient's well-being, it is essential that rapid digitalization be undertaken forthwith.

I. R. G.

ALLEN, F. M.: *Theory and Therapy of Shock: Excessive Fluid Administration.* Am. J. Surg. n.s. **61**: 79–92 (July) 1943.

"The irreversibility of very advanced shock is undisputed. Any therapeutic advance requires an attack on this problem of irreversibility. Although Moon furnished the best phrasing of the idea that 'the wheal is shock in miniature,' he did not draw the therapeutic inference which seemed to me logical. Is it rational to try to prevent formation of the wheal? Since shock is by definition a fluid shift, and the injured tissues evidently somehow need fluid to form the 'wheal,' why not help them to form it by supplying a fluid that will pass readily through the capillary walls?