fairly normal respiration, and the cyanosis was relieved. The blood pressure gradually rose to 140/60. However, hemorrhage continued from the tracheobronchial tree, nasopharynx, and into the paraorbital tissues with marked swelling of the right cheek. An incision was made inside the mouth to decompress the swelling of the right cheek, and a pressure bandage was placed over the eyes. The nasopharynx was packed through the mouth to control the hemorrhage and also to prevent blood from running into the trachea; the anterior nares were then packed with gel foam. The bronchoscope was left in place for fifty minutes, but bleeding from the tracheobronchial tree continued, so an endotracheal tube was inserted to facilitate aspiration and to maintain an adequate airway. The patient was returned to his room in fair condition. After returning to his room, the patient was placed on continuous oxygen, the tracheobronchial tree was aspirated frequently, and a blood transfusion was started. There were definite Cheyne-Stokes respirations for the first hour after being returned to his room, and he did not regain consciousness for about three hours. On the afternoon following the explosion, subcutaneous emphysema developed over the right anterior chest. Bleeding from the tracheobronchial tree continued, and about 600 c.c. of bloody fluid had been aspirated through the endotracheal tube. However, hemorrhage from the nasopharynx and into the paraorbital tissues was apparently controlled. A portable chest roentgenogram examination was made which revealed marked subcutaneous emphysema of the thoracic wall and cervical area; marked bilateral infiltration of the lung fields, although more extensive on the right side; and a small pneumothorax space on the right side with mediastinal emphysema.

"The following morning (Jan. 22, 1950) the patient appeared in fairly good condition. The blood pressure was normal (preoperative level), the subcutaneous emphysema had not increased, there was no dyspnea, and bleeding from the tracheobronchial tree had apparently stopped. The packing from the nasopharynx and nose was removed; also the endotracheal tube. Following this, the patient was able to breathe freely, and was quite comfortable. In the afternoon of the second postoperative day (Jan. 23, 1950) the patient developed progressive respiratory distress, the subcutaneous emphysema increased and extended to the head and neck, and the degree of pneumothorax was greater by physical examination. An intercostal catheter was introduced on the right side and attached to underwater drainage. There was an immediate escape of air with relief of the dyspnea, and the patient was again comfortable. . . . On the fourteenth day following the explosion, Feb. 4, 1950, the patient was discharged to the care of the ophthalmologist. . . . The exact mechanism of the anesthetic explosion in the case presented has not been ascertained."

A. A.


"Although one of the main undesirable effects of the antihistamines in therapeutic usage appears to be due to depression of higher centers, the symptoms observed after overdosage often appear to result from central nervous system stimulation. . . . Inasmuch as the anticonvulsant properties of the barbiturates are well established, it was felt prudent to ascertain whether or not they would serve as a useful antidote in instances of poisoning by antihistamines. . . . Sodium pentobarb-
hital increases the intraperitoneal LD₅₀ of tripelemamine (Pyribenza-
mine), diphenhydramine (Benadryl),
chloroprophenpyridamime (Chlorotrimeton),
and phenindamine (Thephorin) in mice. Sodium pentobarbital acts
similarly for tripelemamine and diphenhydramine in rats but not for
chloroprophenpyridamime. In rats overdosed orally with tripelemamine or
diphenhydramine, the death rate is
not significantly affected by sodium
pentobarbital, although convulsions are
aborted in part and survival time may
be increased. It is suggested that the
degradation products of the antihista-
mine, which are present in greater
amounts after oral administration, may
enhance the actions of sodium pento-
barbital and contribute to the over-all
toxicity. It is recommended that
should the attempt be made in the
clinic to antagonize antihistamine
overdosage with a barbiturate, im-
nEDIATE treatment and removal of any
unabsorbed material are prime requi-
sites in addition to the usual sup-
portive therapy.”

A. A.

TROELL, LARS: Post-Operative Changes
in Circulation and the Effects of
Oxygen Therapy. Acta Chir. Scandi-

“A group of patients on the surgical
service at Karolinska Suk Sjukhuset
has been studied with heart catheteri-
zation. An effort has been made to
determine which changes take place im-
mEDIATELY following surgery and
whether it was possible to enfluence these
changes therapeutically. . . . Twenty-
three patients of operative risks I, II
and III (Gordh (1949)) have been
studied by heart catheterization before,
during, and after operation in order
to observe the effect of various anes-
thesiotics. . . . The average age of the
patients classified as risk I was 39
years; risk II, 48; and risk III, 61.
Of the 10 patients graded as risk I, 6
received spinal anesthesia; 3, narkotal-
curare; and 1, ether. For those in risk
II, narkotal-curaré was given to 5 and
spinal to 1. All patients in risk III
were anesthetised with narkotol-cu-
rae. . . . It has been impossible to
find any evidence that the post-opera-
tive course is influenced by the type
of anesthetic.”

A. A.

THORPE, J. N.: Procaine with Hyalu-
ronidase as Local Anaesthetic

“For the reduction of Colles’s frac-
ture and similar injuries, the anaes-
thetic which is probably most often em-
ployed is nitrous oxide. This, how-
ever, has several drawbacks. . . .
Brachial-plexus block has been used
for the reduction of Colles’s fracture;
but it is time-consuming, not without
danger, and, in inexpert hands at any
rate, often fails. The anaesthetic of
choice in the treatment of this condi-
tion appears to be local infiltration an-
aesthesia. . . . A modification of this
technique has recently been tried at the
Upton Hospital with promising results.
Before injection the local anaesthetic
agent (for Colles’s fracture 20 ml. of
1% procaine) is mixed with 1000
‘Benger units’ of hyaluronidase (‘Hy-
alase’), which promotes diffusion of
injected substances. Two injections are
made: the bulk of the solution is put
directly into the fracture hematoma
from the extensor aspect of the fore-
arm, and 2–3 ml. is infiltrated around
the ulnar styloid process. The anes-
thetic solution diffuses rapidly all
around the injured area and the frac-
ture can be manipulated as soon as the
needle is withdrawn. . . . To date, this
technique has been used in 22 cases of
Colles’s fracture and 4 cases of Pott’s
fracture. . . . Though the series is very
small, we have been struck by the
rapidity with which analgesia is
achieved and by the fact that it has
always been complete.”

A. A.