

afferents. (Downman, C. B. P., and Evans, M. H.: *Distribution of Splanchnic Afferents in Spinal Cord of Cat*, *J. Physiol.* 137: 66 (June 18) 1957.)

**CARDIAC ARRHYTHMIA** Of 70 patients surviving thoracic surgery, 16 developed postoperative atrial arrhythmias. Prophylactic doses of quinidine and atropine are recommended in the immediate postoperative period. (Cerney, O. I.: *Prophylaxis of Cardiac Arrhythmias Complicating Pulmonary Surgery*, *J. Thoracic Surg.* 34: 105 (July) 1957.)

**CAPILLARY RESISTANCE** Immediate capillary response did not develop during spinal anesthesia or during quietly induced inhalation anesthesia. The immediate response did occur after respiratory difficulty as well as after clinical or subclinical anoxia. During the immediate capillary response the plasma contained a substance with properties similar to those of vasopressin. (McCarthy, H. H., Kramer, J., Meyers, V. W., Dietz, N., and Williams, J. W.: *Capillary Resistance in Response to Anesthesia and Surgery*, *A. M. A. Arch. Surg.* 74: 908 (June) 1957.)

**ANTAGONIST** Addition of levallorphan to levorphan in this series did not clinically reduce respiratory depression and seemed to increase incidence of nausea and vomiting. (Rankin, J., Mehnert, J., and Curreri, A. R.: *Effect of Levallorphan Tartrate on Levorphanol Tartrate Analgesia in Postoperative Patients*, *A. M. A. Arch. Surg.* 74: 602 (April) 1957.)

**BARBITURATE POISONING** Five hours of hemodialysis removed 1 gram of amobarbital and secobarbital from a 63-year-old female who had ingested between 2.0 and 2.5 grams of the above barbiturates. Dialysis was thought to significantly accelerate recovery. (Pender, J. C., Beebe, R. T., Garrett, J. J., and Kiley, J. E.: *Emergency Treatment of Barbiturate Intoxication with Hemodialysis*, *Ann. Int. Med.* 46: 997 (May) 1957.)

**NOLUDAR** This is a nonbarbiturate hypnotic used in doses of 200 to 250 mg. In comparing 70 patients receiving Nembutal the night before and Demerol preoperatively with 70 patients receiving 200

mg. of Noludar the night before and 400 mg. of Noludar preoperatively, no significant difference was noted. (Badnay, P. A.: *Noludar, Useful Sedative-hypnotic Drug*, *Postgrad. Med.* 21: 617 (June) 1957.)

**TRANQUILIZERS** Tranquilizers are useful therapeutic agents but a basis for rational use still remains to be developed. Their secondary reactions may affect patients preoperatively and postoperatively, as well as during anesthesia. (Moyer, J. H., Pevey, K., and Kinross-Wright, V.: *Tranquilizing (Ataractic) Agents: Current Evaluation of Their Clinical Use in Patients Who Are Not Hospitalized*, *GP* 15: 97 (June) 1957.)

**TRANQUILIZER** The death rate of mice receiving amphetamine was reduced by administration of phenobarbital, chlorpromazine or reserpine. (Lasagna, L., and McCann, W. P.: *Effect of Tranquilizing Drugs on Amphetamine Toxicity in Aggregated Mice*, *Science* 125: 1241 (June 21) 1957.)

**LOCAL ANESTHESIA** Use of Carbocaine in 1,501 procedures produced the impression that it is of longer duration, perhaps less toxic and may be effective with lower concentrations of epinephrine. (Dhuner, K. G., Oljelund, O., and Agesen, G.: *Carbocaine, New Local Anesthetic Agent*, *Acta chir. scandinav.* 112: 350 (April) 1957.)

**TRACHEOTOMY** Twenty-five tracheotomies were done in 10,709 major surgical patients under local or general anesthesia. The former technique is preferable and often the only safe method to use. (Whitaker, H. T., and Lee, S. S.: *Indications for Tracheotomy*, *Ann. Surg.* 145: 974 (June) 1957.)

**EVALUATION FOR SURGERY** The reduction of operative morbidity and mortality requires greater attention to the preoperative study and preparation of the patient. Recording of fluid input and output and the routine use of the bedside cough test, vital capacity, blood volume determination and sigmoidoscopic examination are recommended. Use of elastic stockings and intelligent efforts at dietary

balance are helpful. Remember the patient's condition may be changed because of potent drugs he has been taking for hypertension or arthritis. Also, he may be unusually sensitive to certain drugs. (Zollinger, R. N.: *Preoperative Evaluation for Major Surgery, Postgrad. Med.* 21: 609 (June) 1957.)

**STOKES-ADAMS DISEASE** Sympathomimetic amines are effective in relieving Stokes-Adams attacks both by increasing ventricular rate in complete blocks and by abolishing a partial atrio-ventricular block. Quinidine and procaine amide are contraindicated. In presence of partial or complete atrio-ventricular block, quinidine and procaine amide produce ventricular extrasystoles, ventricular tachycardia, and ventricular fibrillation by depressing higher ventricular Purkinje centers allowing multifocal ventricular centers to dominate in ventricular depolarization. (Murray, F. G.: *Stokes-Adams Disease, New England J. Med.* 256: 643 (April 4) 1957.)

**SHOULDER-HAND SYNDROME** Various forms of therapy were used in a series of 73 cases of shoulder-hand syndrome, with best results obtained by the use of ACTH or cortisone in conjunction with routine physiotherapy. Repeated stellate ganglion blocks with routine physiotherapy gave less satisfactory results than more intensive physiotherapy alone. (Rosen, P. S., and Graham, W.: *Shoulder-Hand Syndrome, Canad. M. A. J.* 77: 86 (July 15) 1957.)

**EPILEPSY** On the basis of effectiveness, toxicity, and cost, phenobarbital is chosen as the best drug to control major grand mal epilepsy, being given general preference over Dilantin. (Livingston, S.: *Drug Therapy for Childhood Epilepsy, J. Chronic Diseases* 6: 46 (July) 1957.)

**CONTROLLED RESPIRATION** (*Ann. New York Acad. Sc.* 66: 891 (April) 1957.) The positive airway pressure gradient in natural breathing is identical to that induced by positive pressure applied at the mouth. The volume uptake at the same pressure gradient is identical.

Equal ventilation to perfusion ratios, whether achieved by natural or artificial ventilation, seem to result in equal uptake of oxygen and elimination of carbon dioxide. Artificial ventilation varies from the normal in its impairment of venous return, which in abnormal states may lead to a decreased cardiac output. When artificial ventilation is elected, quantitative measurements of pulmonary ventilation are essential. (Spencer, W. A.: *Factors of Significance in Respiratory System.*)

Controlled respiration applied to normal individuals by any reasonable method will be well tolerated. Under conditions of circulatory stress (deep anesthesia, spinal anesthesia or ganglionic blockade) controlled respiration may produce a profound depression of blood pressure and cardiac output. The anesthetist may combat this depression by vigorously supporting the patient's circulation or by use of pressure breathing with a low mean mask pressure. (Maloney, J. V., Jr., and Whittenberger, J. L.: *Direct Effects of Pressure Breathing on Pulmonary Circulation.*)

Controlled respiration is quite distinct from assisted respiration. A disintegration of normal respiratory control may be effected either by pharmacological or by mechanical means but it is accomplished most reasonably by the two acting in concert. The "educated" hand is not as learned as one might wish for purposes of adequate respiratory exchange. When control of respiration is established control of the over-all anesthetic state may be lost. (Little, D. M., Jr.: *Methodology of Controlled Respiration.*)

Lest the enthusiasm for controlled respiration be exaggerated, the general areas in which harm may come through controlled respiration are: the possibility of producing an effective anesthetic overdose; the production of depression of the circulation in patients who have circulatory or respiratory insufficiency; and the production of respiratory acidosis. In the patient with healthy lungs, controlled respiration is easy to apply and is well tolerated; but much more study is necessary to define its limitations and advantages for patients who are critically ill. (Papper, E. M.: *Evolution of Controlled Respiration in Anesthetic Practice.*)

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