

of blood by oxygen. The diagram tape is moving at a constant speed; the degree of blood saturation can be determined directly on the scale of the apparatus; it does not suffer from vibrations and shaking and can be used on planes, autocars and in racing. The oxyhaemograph can work for many hours without regulation. (*Kreps, E. M., and others: Self-Recording Cathode Oxyhaemograph, Vopr. Med. Khimii 2: 457 (1956).*)

PULMONARY EMBOLISM Symptoms and physical findings associated with fatal pulmonary embolism are (in order of decreasing frequency): tachycardia, cyanosis, dyspnea, tachypnea, diaphoresis, hypotension, cough, rales, hemoptysis and pain. In differentiating massive pulmonary embolism from acute myocardial infarction, it is to be noted that cyanosis is uncommon in myocardial infarction unless cardiac failure supervenes. The combination of restricted activity, fever and tachycardia prior to operation suggests the presence of thrombosis, and in these patients preoperative prophylaxis is of equal importance to postoperative therapy. The use of intravenous infusions in the lower extremities of patients whose activity may be limited postoperatively should be condemned. (*Anderson, M. C., and Shields, T. W.: Significance of Fatal Pulmonary Embolism in Immediate Postoperative Period, J. A. M. A. 167: 422 (May 24) 1958.*)

TRANSFUSION REACTION The use of chlorpheniramine (Chlor-treimeton) in the prophylaxis of pyrogenic reaction to blood transfusion has been studied in 200 blood transfusions. The results of this control study indicate that there is no justification for the routine prophylactic use of an antihistaminic in each bottle of transfused blood in an effort to prevent pyrogenic reaction. These conclusions do not apply in the instance of patients with a known history of allergy. (*Hobsley, M.: Chlorpheniramine Maleate in Prophylaxis of Pyrexial Reactions During Blood Transfusions, Lancet 1: 497 (March 8) 1958.*)

TRACHEOSTOMY IN BRONCHIECTASIS Seven individuals with extensive bilateral bronchiectasis, excessive secretions, and severe pulmonary insufficiency were treated utilizing elective permanent

tracheostomy. All patients were supplied with suction apparatus for tracheobronchial aspiration at home. Self aspiration of secretions proved extremely effective in long term management of individuals in whom postural drainage, frequent bronchoscopy, and other treatment had proved inadequate. (*Overhold, R. M., and Segal, M. S.: Long Term Tracheostomy in Extensive Bilateral Bronchiectasis, New England J. Med. 257: 1108 (Dec.) 1957.*)

HEAD AND NECK CANCER In the aged patient the selection of anesthetic agent for head and neck surgery is of the utmost importance. Light anesthesia, adequate blood and electrolyte replacement and the avoidance of unnecessary vasoconstrictors is essential. Inept anesthesia is readily recognized by a prolongation of postoperative recovery. The estimated incidence of carotid sinus reflex difficulties in these patients is 30 per cent. It may be prevented by infiltration of the carotid bulb region with 1 per cent procaine. (*Conley, J. S.: Significance of Cancer of Head and Neck in Aged, Geriatrics 13: 197 (April) 1958.*)

ANESTHESIA FOR T AND A Magill endotracheal tube fitted with a nasal connecting piece is passed through the mouth and fixed carefully in the middle by strapping below the lower lip. The Boyle-Davis mouth gag is then introduced over the tube. The gag may be opened as wide as required with the surgeon being unaware of the presence of the tube in his field of operation. (*Rotter, K., and Mousford, L.: Airway in Tonsillectomy, Lancet 1: 772 (April 12) 1958.*)

INTESTINAL SURGERY Depth of anesthesia, muscle relaxation, unobstructed airway, hyperpyrexia, shock, hypodrenism, antihypertensive therapy, abdominal reflexes and biceps are problems which may occur during gastrointestinal surgery. (*Artusio, J. F., Jr., and Mazzia, V. D. B.: Physiological Problems in Anesthesia During Surgery of Gastrointestinal Tract, Surg. Clin. North America 38: 321 (April) 1958.*)

PYLORIC STENOSIS One hundred and fifty infants were operated upon for hypertrophic pyloric stenosis. The method of anesthesia in 142 of these was with local

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anesthesia, using 0.25 per cent lidocaine with epinephrine. The nerves to the right upper rectus muscle were blocked bilaterally, using a total of 12 ml. of solution. Two infants had convulsions when larger amounts were injected. There were no deaths in the series. (*Leatherdale, R. A. L.: Anaesthesia for Rammstedt's Operation, Lancet : 932 (May 3) 1958.*)

ADRENALECTOMY Anesthetic premedication for this procedure consisted of pentobarbital, meperidine and atropine. Induction with thiopental sodium and tubocurarine was followed by endotracheal intubation, and maintenance was with nitrous oxide, oxygen and ether. An internist supervised preoperative and postoperative cortisone medication, and intravenous hydrocortisone was available in operating and recovery rooms. (*Junker, B. J., and others: Anesthesia for Adrenalectomy, J. A. M. A. 166: 1824 (April 12) 1958.*)

PORPHYRIA Porphyrin is a dominant non-sex linked defect in porphyrin metabolism with increased urinary excretion of uroporphyrin and coproporphyrin. These substances produce reddish black color of urine, particularly evident if urine has been exposed to sunlight. Symptoms are varied but prominently include abdominal pain, central and peripheral neuropathy with psychotic behavior. Acute exacerbations of the disease related to barbiturate administration, alcohol ingestion and surgery. Mortality in an acute attack may vary from 50 to 90 per cent. (*Seide, M. J.: Porphyrin: Report of Nine Cases Diagnosed in Hartford Area, Including Family with Three Affected Members, New England J. Med. 258: 630 (March) 1958.*)

INTUBATION GRANULOMA In spite of all measures of prophylaxis against laryngeal granuloma, the lesion may nevertheless occur and this occurrence does not necessarily reflect unfavorably on the anesthesiologist. One of the commonest causes of litigation in these cases is unwise management of the lesion or neglect by the anesthesiologist to visit the patient postoperatively. Removal of the granuloma is not necessary unless the lesion interferes with respiration and phonation. Rather, the treatment of choice is strict voice rest without surgery; the polyp will eventually be ejected by self amputation. The anes-

thesiologist can protect himself against lawsuit by close postoperative follow-up. Hoarseness, dysphonia or persistent sore throat indicates the need for immediate consultation by a laryngologist. Special precaution should be exercised in the case of the patient who uses his voice professionally or who has had previous laryngeal surgery. (*Barton, R. T.: Medicolegal Aspects of Intubation Granuloma, J. A. M. A. 166: 1821 (April 12) 1958.*)

TRACHEAL OBSTRUCTION Tracheal obstruction was caused by a subglottic, submucosal, tracheal hemangioma in a one month old infant. The hemangioma was not grossly apparent by either laryngoscopy or bronchoscopy. Review of literature and of this case indicates diagnosis of this lesion is difficult and that it may be a frequent cause of intermittent tracheal obstruction in infants under one year of age. Irradiation preceded by tracheotomy is recommended as treatment of choice. (*Doermann, P., Lunseth, J., and Segnitz, R. H.: Obstructing Subglottic Hemangioma of the Larynx in Infancy, New England J. Med. 258: 68 (January 1958.)*)

MUSCULAR DYSTROPHY Twelve patients with muscular dystrophy were studied by right heart catheterization and electrocardiography. Tachycardia was noted in ten patients, and eight of the twelve had abnormal QRS complexes in the electrocardiogram. The data from this study supports the possibility that some of these patients were on the verge of congestive heart failure. They did not pass into frank failure because of the limited demands placed on their circulation. There was no pulmonary hypertension in this group. (*Gailani, S., and others: Muscular Dystrophy Catheterization Studies Indicating Latent Congestive Heart Failure, Circulation 17: 583 (April) 1958.*)

TETANUS A 43-year-old woman developed severe tetanus following a left pulmonary lobectomy. Her course was complicated by bronchiectasis, empyema, bronchopleural fistula, and peripheral circulatory failure. Her disease was successfully treated with antitoxin, antibiotics, tubocurarine, and intermittent positive pressure respiration. She required the full time attention of anesthetists for three