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 Porphyria 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.: Porphyria: 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 anesthesiologist 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 (Jan.) 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

weeks. (*Wilton, T. N. P., Sleight, B. E., and Chandler, C. C. D.: Tetanus, Lancet 1: 940 (May 3) 1958.*)

CURARIZATION FOR TETANUS Two children with severe tetanus were treated with tubocurarine and intermittent positive pressure respiration after large doses of hypnotic drugs and mephenesin had failed to control the spasms. Curarization required an average of 160 mg. daily in one child, and 140 mg. in the second child. The requirements were constant for fifteen and thirteen days, respectively. Sedative and hypnotic drugs were used sparingly after curarization in the first case, and hardly at all in the second. Both children had complete recovery. (*Powell, K. J., Brimblecombe, F. S. W., and Stoneman, M. E. R.: Treatment of Severe Tetanus by Curarisation and Intermittent Positive-Pressure Respiration, Lancet 1: 713 (April 5) 1958.*)

MORAL RESPONSIBILITY In practicing clinical research, there is an obvious conflict which is not experienced in purely medical work. The physician's care is focused first, last and all of the time on his patients; but the good investigator must be very much interested in his problem. There are many other loyalties, however, common to both of these men which conflict with that to their patients—responsibilities for teaching, for their families, for their livelihood, their own health and recreation, and perhaps for Christian, social, or political work. The investigator has just one more loyalty to which he must give correct priority—loyalty to his particular search for the truth. (*Special Article—Moral Responsibility for Clinical Research, Lancet 1: 902 (April 26) 1958.*)

MASS CASUALTIES In civil and military emergencies involving mass casualties, the usual methods of anesthesia may not be applicable. A system of anesthesia involving only an intermittent positive pressure artificial respiration unit utilizing atmospheric air has been tested. The only drugs employed were pentothal, meperidine and *d*-tubocurarine chloride. The technique is simple in the hands of an experienced anesthetist. On the other hand, ether and air administered by open mask or with a vaporizer is undoubtedly less dangerous in the hands of people with little training. (*Ruben, H., and others: Anaesthesia in Mass Emergencies, Lancet 1: 460 (Mar. 1) 1958.*)

PROGRESSIVE CARE Grouping of acute patients needing special care will improve their care and reduce hospital cost. The Manchester Hospital in Manchester, Connecticut, has also introduced a self-service unit where patients can recuperate while still remaining in the hospital under some supervision. Progressive care requires frequent transferring of patients but is liked by the hospital staff, patients and medical staff. (*Thoms, E. J.: Report on Progressive Care—It Works, Mod. Hosp. 90: 73 (May) 1958.*)

HOSPITAL INFECTIONS Staphylococcus infections in hospitals are becoming more widespread because of the development of resistant strains, modification of the resistance of the patient by such drugs as corticosteroids and antibiotics given for "prophylaxis," and the neglect of the principles of asepsis and good housekeeping by many hospital personnel. Suggestions for control include the following: keep the number of personnel present in the operating room to a minimum, not wear scrub clothes outside the operating room, change masks frequently, avoid rough handling of tissues and creation of hematomata, and clean anesthetic equipment between patients. Patients who are particularly susceptible to infection with hospital staphylococci, such as the newborn, the very aged, and patients receiving steroids should receive care to protect them from undue exposure to infection. (*Jawetz, E., and Grossman, M.: Three Ways to Fight Infection, Mod. Hosp. 90: 92 (May) 1958.*)

INVESTMENTS The Canadian Anaesthetists Society has authorized the incorporation of an open end mutual investment fund to provide a vehicle for the investment of savings by members. (*Medical Economics, Canadian Anaesthetists Mutual Accumulating Fund. Canad. M. A. J. 78: 800 (May 15) 1958.*)

TETRACAINE TOXICITY A review of literature by several authors indicates a significantly higher incidence of toxicity reactions to 2 per cent tetracaine than to 5 per cent or 10 per cent cocaine, used