

obstetricians and anesthesiologists. The field of analgesia during labor must be shared, the anesthesiologist must receive information concerning the patient's condition, and the anesthesiologist must be called soon enough to allow familiarity with the patient and her problems. (*Rhu, H. S., Jr.: Editorial—Obstetric Anesthesia, Obst. & Gynec. 11: 728 (June) 1958.*) (*Abstractor's note: A general acceptance by obstetricians of the enlightened attitude expressed by this editorialist would alleviate a large number of the problems encountered by many anesthesiologists in their relations with obstetrical services.*)

**PITOCIN OVERDOSAGE** A term primigravida who had just received spinal anesthesia for delivery mistakenly received 1 cc. of Pitocin in place of the 50 mg. of Demerol ordered. Tetanic uterine contractions were blocked by open-drop ether anesthesia carried to plane two of stage three. Epinephrine might also have inhibited the myometrium but it would have added the risk of cardiac arrhythmia. Delivery was accomplished without incident. (*Watrous, J. B., Jr., and others: Pitocin Overdosage in First Stage of Labor, Obst. & Gynec. 11: 665 (June) 1958.*)

**SPINAL AGENTS** Although nupercaine spinal anesthesia produces a long block, anesthesia is often inadequate necessitating supplementary anesthesia. One hundred patients who received Xylocaine were compared with 100 patients who received nupercaine for spinal anesthesia for vaginal deliveries. Xylocaine was completely adequate in 92 per cent of the cases as compared to 48 per cent for the nupercaine series. (*Phillips, O. G., and others: Spinal Anesthetic Agents for Vaginal Delivery, Obst. & Gynec. 11: 680 (June) 1958.*)

**NEWBORN BLOOD OXYGEN** A group of fifteen newborn infants whose mothers received oxygen through a BLB mask prior to delivery had considerably higher average partial pressure of oxygen in the umbilical vein blood compared with

infants whose mothers did not receive oxygen. Whether the administered oxygen benefited the newborn child is difficult to answer. (*McClure, J. H.: Newborn Blood Oxygen, Obst. & Gynec. 11: 696 (June) 1958.*)

**OBESITY** In a study of 747 parturients weighing two hundred pounds or more, an increased incidence of toxemia of pregnancy and chronic hypertensive disease of pregnancy was found. Obese patients tended to have large babies often necessitating cesarean section. They had a high incidence of spontaneous, uncomplicated, unsterile deliveries without anesthesia. Conduction anesthesia was infrequently used usually because of associated technical difficulties. (*Witten, S. B.: Labor in Obese Patient, Obst. & Gynec. 12: 99 (July) 1955.*)

**OBSTETRIC ANESTHESIA** Occurrence of cardiac arrest during an otherwise uncomplicated vaginal delivery under cyclopropane anesthesia stresses the importance of the presence of an anesthesiologist in delivery rooms, as well as having available all equipment necessary to cope with this emergency. (*McBurney, R. D.: Cardiac Arrest: Case Report, West. J. Surg. 66: 150 (May-June) 1958.*)

**PORPHYRIA** Experience with porphyria in pregnancy emphasizes the avoidance of barbiturates, alcohol, and intravenous barbiturate anesthesia. In these cases chlorpromazine has been used successfully for sedation, and spinal anesthesia for surgery. (*Neilson, D. P., and Neilson, R. P.: Porphyria Complicated by Pregnancy, West. J. Surg. 66: 133 (May-June) 1958.*)

**INFANT RESUSCITATION** There is at present no recognized method of artificial respiration which is effective in securing adequate tidal exchange in the apneic infant other than positive/negative pressure through a mask or endotracheal tube. (*Editorial: Morbid Anatomy and Function in Infant Lungs, Canad. M. A. J. 79: 47 (July 1) 1958.*)

The "Briefs" of Russian literature were taken from *Excerpta Medica's* "Abstracts of Soviet Medicine," which is supplied through the Public Health Service of the National Institute of Health.