

“sphincter” which separates the gastric and esophageal lumens has been attributed to three kinds of mechanisms acting independently or in concert: (1) pinching or angulation of the esophagus by diaphragmatic action; (2) valvular structures created either by the oblique entry of esophagus into stomach, or by mucosal redundancy; (3) intrinsic contraction of the gastroesophageal junctional area. In this review, the evidence for and against a lower esophageal sphincter is presented. (*Ingefinger, F. J.: Esophageal Motility, Physiol. Rev. 38: 533 (Oct.) 1958.*)

**VENOUS THROMBOEMBOLISM** A major cause of intimal damage is eliminated by avoiding whenever possible the intravenous administration of fluids in the lower extremities. However, when this location is necessary, the routine use of 10 mg. of heparin sodium in each liter of fluid administered is of definite value in minimizing superficial and deep venous thrombosis. (*Anlyan, W. G., and others: Management of Acute Venous Thromboembolism, J. A. M. A. 168: 725 (Oct. 11) 1958.*)

**CATHETER COMPLICATION** Three cases of septicemia due to *Staphylococcus aureus* are described in which the source of infection was a septic phlebitis developing at the site of a polyethylene catheter inserted into an antecubital vein for intravenous therapy. (*Phillips, R. W., and Eyre, J. D., Jr.: Report of Three Cases Due to Staphylococcus Aureus Infection After the Intravenous Use of Polyethylene Catheters for Parenteral Therapy. New England J. Med. 259: 729 (Oct. 9) 1958.*)

**GASTRIC DILATATION** Nasal oxygen may be a cause of acute gastric dilatation and indirectly result in severe embarrassment of respiration. In a study of seven cases resulting in six fatalities, the following etiologic factors were found: (1) position of the nasal catheter, (2) type of injury, and (3) the anatomy and constitution of the patient. Experimental studies on dogs revealed that acute gastric dilatation may cause impairment of respiration, vagal stimulation, myocardial damage and death. (*Marrs, J. W., and others: Acute Gastric Dilatation due to Nasal Oxygen, Ann. Surg. 148: 835 (Nov.) 1958.*)

**PULMONARY EMBOLISM** Causes and preventive measures were studied. Emboli most commonly come from thigh and pelvic veins. However, calf vein flow should be capable of increasing proximal flow. Cine-radiography demonstrated stasis in calf veins during inactivity. Using electrical stimulation calf vein flow could be maintained during surgery, even with curare anesthesia. (*McLachlin, J., and McLachlin, A. D.: The Peripheral Venous Heart; A. M. A. Arch. Surg. 77: 568 (Oct.) 1958.*)

**MITRAL STENOSIS** Eighty operative enlargements of the mitral ostium were performed in the surgical clinic of Gorki Medical Institute. Fatal outcome occurred in 4 cases (5 per cent). The first 18 operations were performed under local anesthesia combined with unilateral vagosympathetic block; two patients died in this group. Thirty-six patients were operated under intratracheal ether-oxygen narcosis with a wide local anesthesia of the reflexogenic zones and the pericardial region; there were 2 fatalities in this group. The remaining patients were operated under narcosis, but without introduction of procaine in the pericardial region. Postoperative haemodynamic changes and respiratory disturbances occurred more often in patients operated under local anesthesia than in patients operated under narcosis despite the fact that narcosis was employed in older patients who had a more severe cardiac condition. General narcosis has decided advantages over local anesthesia. (*Korolev, B. A.: Surgical Treatment of Mitral Stenosis, Eksper. Khir. 1: 14, 1957.*)

**HYPERPYREXIA** A 30 year old male admitted with diagnosis of acute encephalitis, was comatose, with depressed respirations, and body temperature of 106.4 F. His body temperature was reduced with chlorpromazine, merperidine, and ice. Temperature originally fell to 86 F. and then was maintained between 96 F. and 98 F. Shivering was a prominent problem. Respiration was maintained via an endotracheal tube. He was discharged well from the hospital 35 days later. (*Johnston, A. W., and others: Hyperpyrexia in Encephalitis Treated by Hypothermia, Lancet 2: 670 (Sept. 27) 1958.*)