

blocking action and should be administered with caution. (*Grob, D.: Myasthenia Gravis, J. Chron. Dis., 8: 536 (Oct.) 1958.*)

SHOULDER-ARM SYNDROME For successful treatment of this disorder, four basic concepts should be recognized. (1) The disorder is a psychosomatic disease with an anatomic or physiological component and a psychological or psychiatric component, both of which must be treated. (2) An accurate diagnosis must be made before treatment is started. The possibility that the patient has an incompletely reduced dislocation, ununited fracture, or neuroma must be excluded. (3) The physiological component should be treated by functional interruption of the sympathetic nerves to the extremity, thus breaking the vicious cycle of increased sympathetic activity. Either the injection of a short-acting anesthetic agent about the stellate ganglion or surgical resection of the upper thoracic sympathetic trunk on the same side as the disability is effective provided the nerve block is sufficiently complete in degree and duration. Physical therapy may be comfortably performed following the block and is a valuable adjunct. (4) The psychological component of the disease requires that the physician exhibit genuine interest, sympathy, and encouragement toward the patient as a person. Occasionally the special abilities of a psychiatrist are absolutely necessary for the difficult patient. (*Pender, J. W.: Basic Concepts About Shoulder-Arm Syndrome, J. A. M. A. 169: 795 (Feb. 21) 1959.*)

PROPHYLACTIC TRACHEOSTOMY

The objectives are to allow maximum utilization of pulmonary reserve and to prevent postoperative pulmonary complications. Tracheostomy is done in the operating room immediately after completing the primary procedure or during the first few postoperative hours. Scrupulous care of the tracheostomy is essential and includes the following points: (1) Suction must be applied at regular intervals, since exclusion of the larynx from the airway deprives the patient of his ability to cough effec-

tively. (2) The tip of the suction catheter should be allowed to pass beyond the inner extent of the cannula, so that suction is applied deeply but with frequent rest intervals. (3) Oxygen furnished to a plastic tracheostomy cup may be used for most patients, but compressed air is employed for those with severe emphysema. Humidification may be obtained by passage of gas through a wetting agent (Alvaire). (4) Aseptic precautions must be employed, for severe tracheobronchitis can be precipitated by careless handling of suction catheters. (*Starzl, T. E., Meyer, W. H., and Farrell, J. J.: Poor Risk General Surgical Patients, J. A. M. A. 169: 691 (Feb. 14) 1959.*)

PSYCHOGENIC FEVER In a study of all patients admitted for the first time to North Carolina Memorial Hospital in 1956, it was found that the incidence of an initial temperature elevation of 0.8 degrees F. or greater, was found to occur in 3.6 per cent of all first admissions. The incidence of an initial temperature elevation among all patients without discernible reason for fever was 27.2 per cent. The highest incidence of psychogenic fever was in psychiatric patients. The greatest temperature elevation found was 2.7 degrees F. (*White, K. L., and Long, W. N., Jr.: Incidence of Psychogenic Fever in University Hospital, J. Chron. Dis. 8: 567 (Nov.) 1958.*)

POSTOPERATIVE THROMBOEMBOLISM

Disintegration of an increased number of megakaryocytes in the lung capillaries may logically produce a sudden, marked increase in circulating platelets and hence a transient blood hypercoagulability. It is possible that a stressful situation such as a surgical operation produces hypercoagulability through the above mechanism and that thus the stage is set for such thromboembolic complications as pulmonary embolism and coronary, cerebral and other peripheral vascular thromboses. (*Sharnoff, J. G.: Increased Pulmonary Megakaryocytes—Probable Role in Postoperative Thromboembolism, J. A. M. A. 169: 688 (Feb. 14) 1959.*)