

shed) and increase of the P wave (in 13 cases) are also often shown in the esophageal lead. (Maslyuk, V. I.: *Oesophageal ECG Lead in Hypertensive Disease*, *Klin. Med. (Moskva)* 1: 98, 1958.)

BRONCHOSCOPY Bronchoscopy can be performed easily and atraumatically by the novice if the upper respiratory tract and larynx is first anesthetized and a nasotracheal catheter passed blindly. After the tracheobronchial tree is anesthetized via the catheter the bronchoscope is passed in the usual manner using the catheter as a guide. (Thomas, D. E.: *Bronchoscopy Made Easy*, *Amer. Rev. Resp. Dis.* 82:1 (July) 1960.)

POSTOPERATIVE PSYCHOSIS In the majority of 24 postoperative patients, the psychic disorder (alimentary-delirious, hallucinatory-paranoid syndromes, residual delirium, etc.) developed acutely on the second to fourth day after operation and lasted for several days to 2 months. In all cases the main cause of the psychosis was the surgical operation, as both severe psychic and physical trauma. The necessity is stressed of taking into consideration the personality and the psychic make-up of the patient in the pre- and postoperative period. The subsequent following of a protective regime and the establishment of contact between patient and surgeon are of great importance. The widespread use of chlorpromazine (1-2 ml. of a 2.5 per cent solution intramuscularly or 50 mg. internally) in surgical practice is necessary. Chlorpromazine has a general tranquilizing action and will prevent the development of postoperative psychoses. (Shabanov, A. N., Tselibeev, B. A., and Sharinova, S. A.: *Psychic Disturbances Associated with Surgical Operations*, *Sov. Med.* 1: 64, 1959.)

SCIATIC NERVE INJURY Serious sciatic nerve injury can result from injections of commonly used antibiotics and other agents into the buttock, especially in infants and young children. The usual presenting complaint is paralytic foot drop, but this is frequently misdiagnosed as a congenital lesion or the result of unrecognized poliomyelitis. Diagnosis is confirmed by the demonstration

of sensory loss and anhydrosis over the distribution of sciatic nerve branches. Surgical exploration of the buttock reveals marked scarring in and about the sciatic nerve. Recovery is poor in this important, preventable type of peripheral nerve injury which probably occurs more commonly than is usually supposed. The preferred site of injection, when the intramuscular route must be used, should be the mid-anterior aspect of the thigh, with the quadriceps muscle as the recipient area. This affords a greater muscle mass than the relatively small area of the upper outer gluteal quadrant. (Combes, M. A., and others: *Sciatic Nerve Injury in Infants*, *J.A.M.A.* 173: 1336 (July 23) 1960.)

EPIGLOTTITIS Epiglottitis in children is generally abrupt in onset and often progresses from the first symptoms to a fatal respiratory obstruction in four to six hours. The respiratory difficulty is chiefly inspiratory obstruction, although expiratory stridor is also present, particularly if the larynx is involved. There is no true hoarseness, the characteristic sound of the voice being described as "muffled." Frequent swallowing motions are present, and the patient may gag and vomit. The patient exhibits the classic signs of air hunger. The epiglottis is greatly enlarged, with intense redness and edema. If complete airway obstruction occurs, placement of a large intravenous needle (13 or 15 gauge) into the trachea or sublingual area will probably maintain a life-sustaining airway until definitive therapy can be established. Relief of the respiratory obstruction is the prime objective of therapy, and early tracheotomy is frequently indicated. (Vetto, R. R.: *Epiglottitis*, *J.A.M.A.* 173: 990 (July 2) 1960.)

HYPGLOSSAL PARALYSIS Endotracheal anesthesia of more than five hours for correction of aortic isthmus stenosis with the patient in right lateral position was followed by paralysis of the recurrent laryngeal and hypoglossal nerves. The surgery might have contributed to the paralysis of the recurrent nerve but pressure of the endotracheal tube is believed to have been responsible for the damage to the hypoglossal nerve. There was gradual recovery of all symptoms. (Konrad,

R. M., and Lakomy, J.: *Combined Peripheral Paralysis of Hypoglossal Nerve after Endotracheal Anesthesia, Der Anaesthetist* 9: 206 (June) 1960.)

GERIATRIC SURGERY In 373 major surgical emergencies in patients 70 years of age or older, 185 operations were performed with a mortality of 29 per cent. Significant pre-existing medical complications were found to be marked hypertension, bronchitis, severe emphysema, congestive failure, fibrillation, aortic or mitral valvular disease, angina, previous myocardial infarction or cerebrovascular accident, paralysis agitans and severe arthritis, especially if treated with steroids. Rapid digitalization, antibiotics and stir up regimes for pulmonary complications, and "sympathetic cajolery" by experienced nurses are all important for recovery. Skilled and experienced anesthesiologists must handle these cases. Local anesthesia does not appear to lessen mortality, but since it promotes speed and gentleness, which are essential, convalescence appears quicker and smoother after its use. Elderly patients do not stand prolonged operations under emergency conditions. (Bolt, D. E.: *Geriatric Surgical Emergency, Brit. Med. J.* 1: 832 (March 19) 1960.)

LOCAL ANESTHETICS Overdosage of local anesthetic agents is the cause of toxic reactions, sensitivity reactions being probably so rare that they can be ignored. In the United Kingdom cocaine, procaine, tetracaine, dibucaine, lidocaine and piperocaine are the only agents readily available. Phenylephrine and cobefrin have not been widely accepted as providing good vasoconstriction with local anesthetic agents. No drug can be implicated as more apt to cause serious post spinal complications. (Bryce-Smith, M. A.: *Local Anesthetic Drugs, Brit. Med. J.* 1: 1039 (April 2) 1960.)

THERAPEUTIC BLOCK Lumbar procaine block therapy was used in combination with other measures in 50 patients with pelvic inflammation. The results were: lytic fall of temperature, decrease of pain, normalization of leucocytes and a slowing down of the erythrocyte sedimentation rate. A considerable re-

duction of infiltrate was noted in 37 cases; in 8 patients no particular effect could be seen. In all patients the indicated changes occurred in the course of 2-5 days after the block. In some patients the block was repeated. The block did not produce any adverse results. (Balyuba, R. I.: *Lumbar Procaine Block According to Vishnevskii's Method in Inflammation of the Female Genital Region, Ata Zdravookhr. Kaz.* 3: 58, 1958.)

THERAPEUTIC PERIDURAL BLOCK In 20 patients with peptic ulcer 2 per cent procaine was injected in the zone D7-8 in an amount of 15-20 ml. Two patients received one block, 13 received two and 5, three blocks. After the block the 'crater' sign disappeared in 9 persons, and in 6, scar changes were found in the region of the former 'crater.' The pains and dyspepsia disappeared, the evacuatory and motor functions of the stomach were normalized and the pylorospasm was abolished. The secretory function was unchanged. The method of peridural block gave no side effects. It may be recommended for use in patients with uncomplicated peptic ulceration. (Andreeva, M. N., and Nikitin, V. M.: *Use of Peridural Block in Treatment of Peptic Ulcer Patients, Trudy I Severo-Zapad. Nauch. Konf. Terap. (Smolensk)* p. 162, 1958.)

PULMONARY STRUCTURE Connective tissue of the lung includes ground substance of connective tissue including basement membrane and reticular, collagen and elastic fibers. Freeze-dry lung preparations show that the noncontiguous cellular layer of the alveoli is covered by a noncellular homogeneous layer next to the air space. Smallest elastic fibers in alveoli, pleura and bronchi are about 80 angstrom units in diameter and have a periodicity of about 150 angstrom units. It is possible that all pulmonary connective tissue contributes to its elastic properties. The lung may be considered primarily as an organ of connective tissue. (Gersh, I.: *Some Non-Cellular Structures of Lung, Amer. Rev. Resp. Dis.* 81: 736 (May) 1960.)

ALVEOLAR SIZE Relative alveolar size was determined in laboratory animals and man using a standardized technique involving fixa-