was not a direct effect of the drug on the brain. Animals could be maintained in a somnolent state with flaxedil alone, but environmental stimuli produced desynchronization and arousal. (*Hodes, R.: Electrocortical Synchronization Resulting from Reduced Proprioceptive Drive Caused by Neuromuscular Blocking Agents, Electroencephalog. Clin. Neurophysiol. 14: 220 (Apr.) 1962.*)

ALKALOSIS AND EEG Patients were lightly anesthetized with ether or nitrous oxide, then were passively hyperventilated with a Jefferson ventilator for three to four hours. Eighty per cent nitrous oxide or 4 per cent ether was used. Arterial blood samples drawn at intervals showed average P_{CO_2} of 14 mm. of mercury and average *p*H of 7.6. The patients failed to show prominent slow activity on the electroencephalographic pattern. This type of change has been described by others during alkalosis, and attributed to cerebral vascular constriction and hypoxia. (*Hughes, J. R., and others: The EEG in Hyperventilated, Lightly Anesthetized Patients, Electroencephalog. Clin. Neurophysiol. 14: 274 (Apr.) 1962.*)

ANTICHOLINESTERASE POISONING In organophosphorous cholinesterase poisoning death can be assigned to combinations of central respiratory inhibition, bronchospasm and hypersecretion in the respiratory tract, vasodilation, neuromuscular paralysis, and convulsions of central origin, all assumed to be the direct result of accumulated acetylcholine. Of these atropine can only reduce the sensitivity of the end-organs in the respiratory tract. To test the hypothesis that more effective cholinolytic compounds than atropine can be found, 34 synthetic compounds were screened for potency in mice and rats. G-3063 and Win 5779-6 were two of the most promising. Combinations of these drugs with atropine and cholinesterase-reactivating oximes such as P-2-S gave greater protection. Triflupromazine also raised the poisoning threshold. (*Coleman, I. W., Little, P. E., and Bannard, R. A. B.: Cholinolytics in the Treatment of Anti-cholinesterase Poisoning, Canad. J. Biochem. Physiol. 40: 815 and 827 (June) 1962.*)

PHEOCHROMOCYTOMA The persistent hypertension of patients with this tumor is of no special worry to the anesthetist; it is the paroxysmal hypertension superimposed on that already present that must be controlled. Phentolamine hydrochloride (Regitine) used intravenously in dosage of up to 5 mg. repeated as required is a quick-acting, effective blocking agent of short duration. Unfortunately the fall in blood pressure is accompanied by tachycardia, and the additive effects with preexisting tachycardia may be alarming. Phenoxybenzamine (Dibenzyline) is a more potent blocking agent primarily used preoperatively to stabilize the patient's blood pressure at a more physiological level. Fifty milligrams diluted in 250–500 ml. may be given intravenously on four successive preoperative days. Because its onset of action is slow (about an hour), it should not be given during the operation. Blood loss during removal of these tumors can be large and must be meticulously replaced. After removal of the tumor, noradrenaline 8 mg./1,000 ml. is infused empirically to sustain a systolic blood pressure of about 120. This dosage is gradually reduced, weaning usually occurring within 24 hours. Ganglion blocking agents should not be used, since a further rise in blood pressure may result. (*Ross, E. J., and others: Management of Cases of Pheochromocytoma, Proc. Royal Soc. Med. 55: 427 (June) 1962.*)

SCLEREMA NEONATORUM This process is characterized by non-pitting induration of subcutaneous tissue. The skin over the involved areas seems bound to the underlying structures and assumes a cool, smooth, purple appearance. Progression of the process to involve the skin of the chest with progressive respiratory distress is the usual terminal event. Etiology is unknown but may be due to insufficient peripheral circulation such as occurs during shock or exposure to cold. Successful treatment with adrenal steroids has been reported but mortality remains high. (*Rader, L. E., and Williams, G. R.: Sclerema Neonatorum Complicating Surgical Procedures, A.M.A. Arch. Surg. 84: 625 (June) 1962.*)