EXTERNAL CARDIAC MASSAGE  In performing external cardiac massage in an adult, it is only necessary to move the lower part of the sternum toward the spine about 1 to 1 1/2 inches. However, the operator should strive for a depression of 3 inches since, unless the patient is on a very firm surface, the operator will think he is moving the sternum adequately when all he may be doing is bouncing the patient's bed. The most likely cause for the heart to fail to continue beating is that the ventricles have fibrillated. If a defibrillator with 100 to 500 volts is available, defibrillation may be carried out without opening the chest. For an extremely large patient, particularly if the chest wall is obese, a voltage as high as 700 may be required. Any voltage exceeding 200 is dangerous to the operator (electrocution) unless he uses properly designed electrodes and avoids touching the patient or the electrodes during the procedure. If external massage does not produce an adequate carotid pulse with restoration of normal pupils, the operator should not delay in opening the chest. (Bradley, H. H.; External Cardiac Massage. Proc. Roy. Soc. Med. 55: 29 (Aug.) 1962.)

EEG AFTER CARDIAC ARREST  Prediction from common clinical signs is difficult in early stages of cardiopulmonary resuscitation as to whether a patient will recover fully or whether irreversible cerebral damage has occurred. Recovery of cerebral function as detected by electroencephalogram after re-establishment of circulation depends upon a number of factors, among the most important are the total duration of inadequate cerebral circulation, patient's body temperature, and adequacy of ventilation. EEG changes in children are more obvious and dramatic than in adults, but careful and well-timed EEG studies should yield valuable information about the chances of survival, after cardio-respiratory resuscitation at any age. Occur