

Effects of Season on Death Due to Hemorrhage, Arch. Surg. 88: 448 (Mar.) 1964.

HYPERTENSION Polypeptide vasoconstrictor activity was assayed in the peripheral venous blood of 45 hypertensive patients and 20 normal subjects. Average activity was significantly increased in all hypertensive groups, and activity tended to be much higher in patients with renovascular and malignant hypertension than in primary hypertension. There was no correlation between vasoconstrictor activity and renal excretory function. Plasma level of vasoconstrictor activity did not correlate with mean arterial pressure except when malignant or renovascular hypertension was present. A significant inverse relationship was found between the serum potassium concentration and vasoconstrictor activity: as activity levels increased, the potassium fell. Possibly a renin-like substance may be present in various hypertensive states in amounts sufficient to depress activation of the renin-angiotensin-aldosterone mechanism. (*Fitz, A. E., and Armstrong, M. L.: Plasma Vasoconstrictor Activity in Patients with Renal, Malignant, and Primary Hypertension, Circulation 29: 409 (Mar.) 1964.*)

AORTIC CLAMPING In nine cases blood pressure rose by 14 to 64 per cent of the preoperative level when the aorta was clamped. To counteract this rise, 1.03 mg. to 14.09 mg./minute (in a total dose of 32 mg. to 310 mg.) of Arfonad was infused for 21 minutes to 2 hours. These doses kept the blood pressure at +34 to -14 per cent of the preoperative level. It took an average of 30 minutes for the blood pressure to stabilize after removal of the aortic clamps. Conclusions were (1) the maximum total dose of Arfonad should be 300 mg.; (2) infusion should be at 1.5 mg./minute; (3) blood pressure during Arfonad administration should be kept at +25 per cent of the preoperative level, if it rises 50 per cent when the aorta is clamped; (4) the infusion should be started five to 10 minutes after clamping of the aorta,

and should be stopped five to 10 minutes before removal of clamps. (*Miyazaki, M.: Hypertension and Anaesthesia, Especially in Cardiovascular Surgery with Circulatory Occlusion, (Japanese), Jap. J. Anaesth. 12: 74, 1963.*)

VALSALVA TEST In normal subjects, a pressure overshoot occurs in both pulmonary artery and peripheral artery together with bradycardia after cessation of straining during the Valsalva maneuver. In patients with right ventricular impairment the pressure overshoot in the pulmonary artery and bradycardia do not occur. If peripheral pressure overshoots and bradycardia does not occur with ordinary clinical measurements, right ventricular impairment can be suspected, but if both peripheral pressure and heart rate changes are abnormal no localization of cardiac disease can be made. (*Malmberg, R., and others: Valsalva Maneuver as a Test of Cardiac Function in Patients with Pulmonary Disease, Amer. Rev. Resp. Dis. 89: 64 (Jan.) 1964.*)

CORONARY VASODILATORS By coronary arteriography, glyceryl trinitrate and erythryl tetranitrate have coronary vasodilating action even in those patients with coronary atherosclerosis. This does not imply that coronary blood flow is consequently improved. (*Likoff, W., Kasparian, H., Lehman, J. S., and Segal, B. L.: Evaluation of Coronary Vasodilators by Coronary Arteriography, Amer. J. Cardiol. 13: 7 (Feb.) 1964.*)

HEMATOCRIT AND CORONARY DISEASE A study comparing hematocrit values of three groups of normal men with those of 200 patients with myocardial infarction showed that hematocrit value does not seem to be a significant factor in predisposition to acute myocardial infarction, except in conditions in which its value is much increased. (*Conley, C. L., and others: Hematocrit Values in Coronary Artery Disease, Arch. Intern. Med. 113: 170 (Feb.) 1964.*)