

LARYNGEAL PAPILOMA Benign laryngeal papillomata are a serious problem in children because they are resistant to treatment, recurrence rate is high and the airway is threatened. Inasmuch as all forms of treatment have been uniformly disappointing, and because surgery or irradiation frequently leads to stenosis and obstruction, treatment should be conservative, with instrumentation limited to removal of growth with cup forceps only as absolutely necessary to maintain an airway, particularly in view of the fact that spontaneous remission is the rule. Mortality is high (12 per cent), chiefly because of complications attendant upon therapy. (*Majoros, M., Parkhill, E. M. and Devine, K. D.: Papilloma of the Larynx in Children, Amer. J. Surg. 108: 470 (Oct.) 1964.*) (EDITORIAL NOTE: General anesthesia in these children represents a real threat to life because of the likelihood of early severe obstruction following loss of consciousness.)

PULMONARY SHUNTING Cardiac catheterization in 12 patients before pulmonary resection showed right-to-left shunting (absolute shunts plus relative shunts caused by regional alveolar hypoventilation in relation to pulmonary capillary blood flow). Five showed absolute right to left shunting. Occlusion of the pulmonary artery to the lung to be removed resulted in a decrease in the total shunt of 8 of the 12 patients; absolute shunting became greater in 2 patients during occlusion, but the amount of shunting did not increase significantly in any of them. (*Swenson, E. W., and others: Vascular Shunts in the Lungs: Clinical Evaluation by Temporary Unilateral Pulmonary Artery Occlusion, J. Thor. Cardio. Surg. 48: 681 (Oct.) 1964.*)

ARTERIAL HYPERTENSION Patients with stages I and IIA of arterial hypertension, whose initial pressure does not exceed 160/90 mm., require no special hypotensive preparation for anesthesia. Patients with an initial arterial pressure exceeding 160/90 mm., and all patients with stages IIB and III of hypertension, must receive a preliminary course of hypotensive drugs (reserpine, dibazol, ephyllin). The hemodynamic changes during inhalational anesthesia with nitrous oxide and oxygen, or

during intravenous anesthesia with intramarkon, were less marked than during intravenous anesthesia with hexobarbital or thiopental sodium. Changes in the patient's position on the operating table must be made slowly and smoothly, otherwise considerable hemodynamic changes may ensue. (*Scherbakova, L. S.: Anaesthesia for Hypertensive Patients, Eksp. Kchir. Anest. (Russian) 3: 67, 1964.*)

ARRYTHMIAS Pronethalol blocks the cardiac effects of both catecholamines and sympathetic activity. When given in moderate doses of 2.5 to 10 mg. intravenously, it is capable of completely abolishing extrasystoles associated with respiratory acidosis and catecholamine release in subjects anesthetized with cyclopropane, halothane or chloroform. The dosage may be repeated if arrhythmias recur. Tachycardia of respiratory acidosis is also abolished. (*Payne, J. P.: Pronethalol in Treatment of Ventricular Arrhythmias During Anaesthesia, Brit. Med. J. 1: 603 (Mar. 7) 1964.*)

CARDIAC PACEMAKER Implanted cardiac pacemakers occasionally become exhausted and fail to stimulate the myocardium. The cardiac responsiveness to the pacemaker was successfully restored with potassium chloride in 2 patients so as to allow time for a new pacemaker to be implanted. The oral administration of potassium is advised as a method of restoring myocardial responsiveness to a partially exhausted electrical pacemaker. (*Walker, W. J., and others: Effect of Potassium in Restoring Myocardial Response to a Sub-threshold Cardiac Pacemaker, New Engl. J. Med. 271: 597 (Sept.) 1964.*)

CARDIAC TELEMETRY A recent development in medical electronics, dynamic electrocardiography, provides records of the electrical activity of the heart on electromagnetic tape while the subject carries on his usual daily activity without medical supervision. The tape recorder is connected to the subject by means of 2 electrodes, one placed over the lateral one-third of the right clavicle and the other over the sixth rib in the left anterior axillary line. During the 10 hour period of recording, the patient keeps a detailed diary of all activities with an entry made at least every fifteen min-