fore, the actual amount of negative pressure required to indicate ventilatory sufficiency differs in the two techniques, but according to their results both methods afford reliable quantitative data for the purpose intended. Since almost all present day gas machines are equipped with a pressure gauge we believe that our modified technique is simpler and adaptable to more widespread utilization by the practicing clinician. There is one point of departure in our clinical experience, *i.e.*, if 20 cm. of negative pressure is sufficient with the original technique, it follows that 10 cm. of water negative pressure would be adequate using the modified technique. In a few instances patients have been extubated with this amount of negative pressure and have had to be re-intubated. It would seem to us that if we follow this reasoning, that 20 cm. of water negative pressure is not adequate evidence of ventilatory sufficiency in *all* patients and perhaps both acceptable figures should be elevated.

We wish to thank Drs. Suwa and Bendixen for the opportunity to read their paper in advance and to comment on it. We are of the opinion that both techniques are valid if the proper requirements for each are utilized.

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Kidneys

RENAL BLOOD FLOW Substantial hypotension induced by adrenolytic agents in normovolemic dogs resulted in diminished renal blood flow. The adrenolytic agents studied did not protect animals from the decreased renal blood flow associated with moderate hemorrhage. The decrease following a small dose of Dibenzyline and hemorrhage was similar to that observed in the untreated animal. Arfonad produced only a slightly greater fall, while Apresoline and larger doses of Dibenzyline resulted in a marked reduction in renal blood flow. (*Muhm, H., and Shumacker, H.: Effects of Adrenergic Blocking Agents on Renal Blood Flow in Normovolemia and Experimental Hypovolemia, Ann. Surg. 164: 51 (July) 1966.*)

PROSTATIC BED HYPOTHERMIA The irrigating fluid (a glycine solution) used in transurethral resections by 2 residents in separate hospitals was cooled to approximately 34 to 36° F. by running it through a Heimbecker heat exchanger. This was used in a total of 80 cases. This produced a local hypothermia, thus resulting in a constriction of the vessels of the prostatic bed during resection. Average blood loss was decreased almost 50 per cent. Because of this decrease in total blood loss there was increased efficiency in resection due to better visibility and time saved in electrocoagulation. In theory at least, the danger of hypervolemia is reduced because of vessel constriction. No complications were encountered which could be attributed to the hypothermia *per se*. The body temperature dropped from 3 to 6 degrees as measured by esophageal thermometers. Despite this drop, no case of cardiac irregularity or rewarming shock occurred. A few of the patients given spinal anesthesia complained of feeling cold and shivered towards the end of the procedure. These symptoms were not encountered in patients operated on under general anesthesia. (*Robson, C. J., and Sales, J. L.: The Effect of Local Hypothermia on Blood Loss During Transurethral Resection of the Prostate, J. Urol. 95: 3 (Mar.) 1966.*)