valid baccalaureate degree, and the education offered in the program would surely be beneficial. However, even before the first class has completed the program, several students have been offered positions by anesthesiologists in Ohio. Other specialists are examining the format closely and, at the time of this writing, Obstetrics/Gynecology has submitted a curriculum patterned after it.

In discussions regarding the program, questions concerning legal problems, insurance coverage, the proper composition of the anesthesia team, etc., invariably arise. At this point, we do not wish to discuss these items. Suffice it to say that solutions to these questions can and will be found should the conceptual and educational principles of the approach prove sound.

Obstetrics

LIDOCAINE AND FETAL PHYSIOLOGY Fifteen experiments were done on eight sheep fetuses whose gestational ages were 120 to 143 days (term is approximately 145 days). The injection of lidocaine, 1 or 2 per cent, in doses of 14.3 to 36.8 mg/kg fetal weight resulted in significant changes in fetal heart rate, EEG, and cerebral blood flow. Significant bradycardia, not influenced by vagotomy, occurred. The electroencephalogram showed slowing, slowing followed by an isoelectric (flat) record, or low-voltage fast activity. Cerebral blood flow decreased, but cerebral metabolism was unaffected. All three values returned to normal within 20 minutes of injection. No attempt was made to quantitate blood levels of lidocaine, so no statement of a critical level of lidocaine beyond which physiologic alterations would be expected can be made. (*Mann, L. I., and others: The Effect of Lidocaine on Fetal Heart Rate and Fetal Brain Metabolism and Function. Am. J. Obstet. Gynecol. 112: 789–795. 1972.*)

Obstetrics

DRUG THERAPY IN PRE-ECLAMPSIA Fifty-two patients in labor with severe pre-eclampsia were treated by intravenous infusion of diazepam and hydralazine. The results of this treatment were compared with the results of two other methods of treatment, a lytic cocktail regimen, and rectal Avertin (tribromethanol). The maximum total dose of diazepam was 300 mg, given in a 21-hour period. The maximum total dose of hydralazine was 280 mg, and the average dose was 75 mg. The treatment was directed toward ensuring a sleepy, rousable patient with a blood pressure below 150/100 mm Hg. Furosemide (Lasix), 40–80 mg, iv, was also given, for edema, and meperidine, 50–100 mg, im, was used for pain.

Avertin was freshly prepared and given rectally in full obstetric dosage according to the manufacturer's instructions. The "lytic" regimen consisted of meperidine (100 mg), chlorpromazine (50 mg), and promethazine HCl (50 mg) in 500 ml of 5 per cent dextrose solution, with the drip rate adjusted to keep the blood pressure below 140/90 mm Hg.

Diazepam and hyralazine gave significantly better control of blood pressure than either of the other regimens, with no adverse reaction except a tendency to hypothermia in the newborn. No patient developed eclampsia during diazepam–hydralazine treatment, but one patient had a seizure during the "lytic" regimen and another seizure after Avertin treatment. (*Joyce, D. N., and Kenyon, V. G.: The Use of Diazepam and Hydralazine in the Treatment of Severe Pre-eclampsia, J. Obstet. Gynaecol. Br. Commonw. 79: 250–254, 1972.*)

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