tivity of mice. J Pharmacol Exp Ther 142: 343–350, 1963

9. Stolk JM, Rech RH: Enhanced effects of d-amphetamine on the spontaneous locomotor activity of rats treated with reserpine. J Pharmacol Exp Ther 158:140–149, 1967
10. Carlson A: The occurrence, distribution and physiologic role of catecholamines in the nervous system. Pharmacol Rev 11:490–493, 1959
11. Holzbauer M, Vogt M: Depression by reserpine of the noradrenaline concentration of the cat. J Neurochem 1:8–11, 1956
12. Paasonen MK, Krayer O: The release of norepinephrine from the mammalian heart by reserpine. J Pharmacol Exp Ther 123:153–160, 1958
13. Adams HR, Dixit BM, Smookler HH, et al: Clinical and biochemical effects of chronic reserpine administration in mongrel dogs. Am J Vet Res 33:699–707, 1972
14. Moore KE, Wright PF, Bert JK: Toxicologic studies with d-methyl-tyrosine, an inhibitor of tyrosine hydroxylase. J Pharmacol Exp Ther 155:506–515, 1967
15. Sulser F, Owens ML, Norwich MR, et al: The relative role of storage and synthesis of brain norepinephrine in the psychomotor stimulation evoked by amphetamine or by desipramine and tetrabenazine. Psychopharmacologia 12:322–332, 1968
16. Hanson Lennart CF: Evidence that the central action of (+) amphetamine is mediated via catecholamines. Psychopharmacologia 10: 289–297, 1967
17. Maynert EW, Kuriyama K: Some observations on nerve ending particles and synaptic vesicles. Life Sci 3:1067–1087, 1964
18. Spector S, Sjoerdama A, Udenfried S: Blockade of endogenous norepinephrine synthesis by a-methyl-tyrosine, an inhibitor of tyrosine hydroxylase. J Pharmacol Exp Ther 147: 86–95, 1966

Finances

COST OF MEDICAL CARE AND SURVIVAL The author has collected and correlated information on the 702 patients admitted to the Surgical Intensive Care Unit (SICU) at Massachusetts General Hospital during 1970, the first complete year of its operation. Approximately three-fourths of the admissions were postoperative cardiac surgical patients, while the rest were critically ill general surgical patients. Mortality rates and costs were considered in relation to length of stay in the SICU. The mortality rate for cardiac surgical patients discharged from the SICU within one week of surgery (comprising about 90 per cent of such patients) was 6 per cent, whereas those discharged after one week suffered 30 per cent mortality. Of the general surgical patients, 45 per cent of those discharged from the SICU in the first week and 60 per cent of those discharged after one week died. The median SICU stay of the cardiac surgical patients was 2.8 days, and that of the general surgical patients, 5.2 days. The estimated daily cost of SICU care was $761, including all drugs, tests, and procedures, and the daily cost was $187 for the rest of the hospitalization. Although the total hospital stays averaged 20.3 days for patients who died and 32.3 days for survivors, those who died stayed an average of 11 days in the SICU, as opposed to 5.6 days for the survivors. Therefore, the total hospital bill was only slightly higher for patients who died. Since the longer stay in the SICU implied more severe disease and less chance for survival, it would appear that cost of medical care is inversely related to survival. In order to effect more efficient utilization of the facility, patients in the SICU were considered to be in one of three classes according to the intensity of care needed. Monitoring, professional case, and laboratory studies were then utilized in relation to the severity of illness. (*Civetta, J.: The Inverse Relationship between Cost and Survival. J Surg Res 14: 265–269, 1973.*)