

and it may, in fact, be produced by a combination of circumstances. Gillespie attributes it to a streptococcal infection brought about by the entrance of the organism into some small abrasion of the mucosa at the time of operation. . . . Mechanical irritation may play a role in production of this complication. . . . Finally, operations involving elevation of a cranial bone flap necessitate a considerable amount of unavoidable forcible movement of the head and neck with possible irritation of structures adjacent to the endotracheal tube." A. A.

COVNER, A. H., AND HALPERN, S. L.: *Fatal Agranulocytosis Following Therapy with "Presidon" (3,3-Diethyl-2,4-dioxotetrahydropyridine), a New Sedative Hypnotic Agent.* New England J. Med. 242: 49-52 (Jan. 12) 1950.

"Among the nonbarbiturate sedative drugs that have recently been introduced has been 3,3-diethyl-2,4-dioxotetrahydropyridine (pyrithyldione), which has been marketed under the trade name of Presidon. . . .

"A case of fatal agranulocytosis . . . indicates that this sedative hypnotic may not be the safe drug it is believed to be. Since most of the indications for sedatives are elective and the conditions for which it is administered benign, it is best to use drugs that have been shown not to be. . . .

"It is believed that the advantages of Presidon over barbiturates are not sufficient to warrant their substitution for the latter drug if our observation of a myelotoxic effect by Presidon is confirmed by other observers." A. A.

CARNEGIE, D. M., AND HEWER, A. J. H.: *Clinical Trial of Xylocaine in Local Anaesthesia.* Lancet 2: 12-14 (July 1) 1950.

"At the invitation of the Faculty of Anaesthetists of the Royal College of

Surgeons of England, we have carried out a clinical trial of the Swedish local analgesic "Xylocaine. . ." Xylocaine has been used as a local anaesthetic in 138 cases. It is a relatively non-irritant analgesic substance of low relative toxicity with rapid onset and prolonged duration of action. In a concentration of 0.5% with adrenaline it produces almost as long an analgesia as 2% solutions. Tactile as well as pain sense is lost. It can be used for topical as well as infiltration analgesia. In the eye it produces no dilatation of the pupil or mistiness of the cornea. Adrenaline 1 in 250,000 is more suitable than 1 in 100,000. The dosage is the same as for procaine with a maximum of 1.0 g., although as a rule lower concentrations of xylocaine are satisfactory." A. A.

AIKENHEAD, D. C.: *Anesthesia in Transurethral Surgery.* Urol. & Cutan. Rev. 54: 290-292 (May) 1950.

"Anesthesia for transurethral surgery is a most interesting procedure as the recipients are in many instances suffering from cerebral, pulmonary, cardiac and circulatory disease. . . . The pre-operative preparation of the patient is as important as the operation. . . . An experienced anesthesiologist may choose a variety of agents which in his or her hands may show little statistical difference. This paper is written for the individual with limited experience in anesthesia for trans-urethral work, I shall choose a sub-arachnoid anesthetic which I believe to be the anesthetic agent of choice for trans-urethral surgery. Certainly elderly males offer various physical handicaps to a quick and easy spinal tap. . . . The patient must remain quiet. Should the former keep squirming as the needle pierces the various dorsal planes I withdraw the needle and have someone administer sufficient 2½%