pine and an antitussive to decrease the toxic potential of the anesthetic, decrease bronchial secretion and depress the cough reflex. The smallest amount of topical anesthetic that will produce anesthesia should be used. In over 90 per cent of anesthetic accidents, the safe dosage has been exceeded. Cocaine has produced severe reactions with 20 mg., although 1.2 Gm. is ordinarily considered the fatal dose. The manufacturer of Pontocaine states that not more than 20 mg. of the drug should be used in endoscopy. The general concensus is that less than 100 mg. should be used. (*Curry, F. J.: Bronchography, Lancet 2: 342 (Nov.) 1956.*)

CAUDAL ANALGESIA This five-year study of various methods of postoperative pain control in rectal surgery included a series utilizing continuous caudal anesthesia for 48 hours postoperatively. The indications are: neurocirculatory asthenia, obesity, asthma, addiction, alcoholism, and early surgery in acute extensive anorectal inflammation. The procedure utilized 1 per cent Xylocaine hydrochloride solution through a polyethylene tube in the sacral canal. (*Moran, R. F.: Evaluation of Various Methods to Manage Postoperative Pain and Morbidity Following Anorectal Surgery, Surgery 93: 102 (Jan.) 1957.*)

SPINAL A careful long-term evaluation of the neurological sequelae of spinal anesthesia in a group of 10,098 individuals revealed that 11 patients with pre-existing neurological disease showed evidence of exacerbation of their disease as a consequence of the subarachnoid administration of a local anesthetic. In these 11 individuals, neurological disease was distributed as follows: spinal cord tumor (1), herpes zoster (1), healed encephalitis (1), protruded intervertebral disc (3), metastatic carcinoma involving spine (2), diabetes with peripheral neuropathy (2), and previous cerebral vascular disease (1). (*Vandam, L. D., and Dripps, R. D.: Exacerbation of Pre-Existing Neurological Disease After Spinal Anesthesia, New England J. Med. 255: 843 (Nov.) 1956.*)

CARDIAC ARREST Vagal reflexes are important in producing cardiac arrest only if severe hypoxia or hypercapnia is present. It is important for the anesthetist to have a finger on one of the patient's arteries at all times. As treatment, one hundred per cent oxygen is administered while the heart is manually squeezed deliberately and firmly 45 to 50 times a minute. Two to three cubic centimeters of 1:10,000 epinephrine or 2 to 4 cc. of 10 per cent calcium chloride are the most effective cardiac stimulants. Isoproterenol hydrochloride, calcium gluconate, and barium chloride were not found to be satisfactory cardiac stimulants. Procaine or procaine-like substances should not be used in treatment of ventricular fibrillation unless the heart has excellent tone and unless the serial method of electrical defibrillation has failed after many attempts. (*Kay, J. H.: Treatment of Cardiac Arrest Occurring During Surgery, J. A. M. A. 163: 165 (Jan. 19) 1957.*)

CARDIAC ARREST This is apparently the first successful and lengthy (12 months) survival of a cardiac arrest complicated by a ventricular laceration treated by a transdiaphragmatic approach. The cardiac arrest recurred during an abdominal exploration prior to a gastrectomy for a large gastric ulcer. Emphasis is placed on the recommendation by Lahey that if cardiac arrest occurs during an upper abdominal operation, cardiac massage should be accomplished through the diaphragm to save time. (*Thomas, G. I., and Harkins, H. N.: Cardiac Arrest Complicated by Ventricular Laceration Successfully Treated Transdiaphragmatically; Case Report, Ann. Surg. 144: 897 (Nov.) 1956.*)

PULMONARY HYPERTENSION Although a rare disease, ten cases are reported, including four autopsies. Two patients died during minor surgical procedures. Findings include progressive exertional dyspnea, syncope and left chest pain. Electrocardiogram and chest roentgenogram show right ventricular hypertrophy. There is a high right ventricular and pulmonary arterial pressure and normal pulmonary capillary pressure. The progress of the disease is an unrelenting downhill course of right ventricular failure. (*Chapman, D. W., and others: Primary Pulmonary Hypertension; Review of Literature and Results of Cardiac Catheterization in*