RESPIRATORY DISTRESS In Chicago, during the last 40 years, the mortality rate of infants has fallen in the first year, 10 per cent; in the first month, 2.5 per cent; in the first week, 0.2 per cent; and in the first day, "practically not at all." Cause of respiratory problems include: initial atelectasis, secondary or reabsorption atelectasis, hyaline membrane disease, alveolar dysplasia, tension pneumothorax, congenital lung cysts, diaphragmatic hernia, and congenital anomalies. Essential principles in management include: avoidance of shock and trauma, conservation in resuscitative measures, and assisting baby to breathe but not taking over respiration. (*Reichert, J. L.: Respiratory Distress in Newborn Infant, Postgrad. Med. 22: 112 (August) 1957.*)

HEPATITIS The occurrence of three consecutive cases of viral hepatitis (with one death) following treatment of postpartum hemorrhage with blood transfusions and fibrinogen lead to the belief that fibrinogen should be used only when definitely indicated as a life saving measure. None of the 619 patients at this center given 1,000 cc. or more of blood (and no fibrinogen) during the same period developed hepatitis. (*Rettew, P. L., Meharg, J. G., and Brubaker, E. R.: Hepatitis Following Therapy for Afibrinogenemia, Obst. & Gynec. 10: 169 (Aug.) 1957.*)

TOURNIQUET After 20 minutes sufficient anesthesia was present from the tourniquet so that additional local anesthesia was not needed in 219 procedures on upper and lower extremities. Tourniquet discomfort appeared in 30 to 40 minutes in the lower extremity and 40 to 60 minutes in the upper extremity. Additional time was obtained by administering more intravenous analgesia or deflating the tourniquet and reinflating after five minutes. (*Coonrad, R. W., and Knight, W. E.: Use of Pneumatic Tourniquet and Local Anesthesia for Surgical Procedures on Extremities, South. M. J. 50: 788 (June) 1957.*)

COLD INJURY While nonfreezing and freezing cold injuries are distinctly different mechanistically and clinically, the difference seems to be one of rate, that is, a slow metabolic strangulation of the cell on the one hand, and a rapid denaturation on the other. The rationale of sympathetic nerve block and use of vasodilators is not immediately obvious because a local nerve block is already present and uniformly produces an hyperemia on rewarming. The value of heparin has not yet been fully determined, although its rationale as a sludge preventative is reasonable. Unfortunately, treatment generally is not initiated until several hours following thawing and the problem is reduced to that of restricting gangrene, maintaining asepsis, debridement, grafting, and treating the late sequelae of pain and vasomotor disturbances. (*Meryman, H. T.: Tissue Freezing and Local Cold Injury, Physiol. Rev. 37: 233 (April) 1957.*)

CURARE IN OBSTETRICS Two cubic centimeters of *d*-tubocurare given intravenously as nitrous oxide-oxygen anesthesia was commenced for vaginal delivery permitted the use of light anesthesia but still provided better muscle rexalation, less blood loss, and quicker recovery from anesthesia than provided by ether anesthesia. No significant difference was noted in fetal mortality figures between this group of 2,500 patients who received curare and the 11,690 other patients delivered in the same hospital during the same period. (*Squire, J. J., and Roberts, L. M.: Curare and Obstetric Anesthesia, Obst. & Gynec. 10: 56 (Aug.) 1957.*)

REPEAT CESAREAN SECTIONS. A maternal mortality rate of 0.16 per cent leads the authors to question the need for sterilizing patients having repeated cesarean sections. In order to avoid the hazards of prematurity, a careful preoperative appraisal must be made of fetal age and maturity; some authors wait until labor actually begins. (*Johnston, R. A., and Morgan, J. R.: An Analysis of 611 Repeat Cesarean Sections, South. M. J. 50: 764 (June) 1957.*)

ABDOMINAL OPERATIONS The anesthesia for 100 abdominal operations was analyzed. Light general anesthesia with relaxants is inadequate for major ab-