A number of patent ductus cases have been operated upon under induced hypotension, and some of the poorest risk patients in this group as well as in the atrial septal defect group have undergone hypothermia. Induced hypotension is of great value in cases of coaretation of the aorta, blood pressure being maintained around 100 mm. Hg during the entire operation. An inadvertent fall in blood pressure is tolerated badly during cardiac surgery, especially when the cardiac reserve is small, but if possible the use of drugs is avoided in the treatment of this condition. Suspension of the operation and gentle inflation of the lungs usually constitutes adequate therapy. If cardiac arrest occurs where valvular stenosis is present, completion of the valvulotomy is essential before any other treatment is attempted. (*Secher, Ole: Problems of Anaesthesia in Relation to Cardiovascular Surgery, Proc. Roy. Soc. Med. 50: 983 (Nov.) 1957.*)

OPEN-HEART SURGERY Two serious complications associated with intracardiac surgery are bronchial hypersecretion and persistant heart block. Bronchial hypersecretion is frequently associated with pulmonary hypertension. Preoperative tracheotomy, and postoperative employment of a Bennett partial assistance respirator help in control of this problem. Isuprel has aided greatly in the treatment of persistent heart block. When block persists at operation in spite of Isuprel administration, an electrode has been sutured into the right ventricle myocardium and connected to an electrical cardiac pacemaker which maintains a ventricular rate of 100 to 110 during the critical postoperative period. (*Allen, P.: Some Basic Features of Open-heart Surgery Using Bubble Oxygenator, Canad. M. A. J. 77: 1125 (Dec. 15) 1957.*)

CARDIO-VASCULAR SURGERY In pericardectomies with the use of a unilateral flap incision, local analgesia is to be preferred, but if the trans-bipleural approach is used intratracheal anaesthesia is preferable. The majority of the mitral stenosis operations were performed under intratracheal anesthesia. In patients with cyanotic heart disease the use of hypothermia is indicated because of the depression of all oxidative processes. In operations performed for portal hypertension the author's method of choice is peridural analgesia. To combat the pain in the postoperative period the author recommends the use of novacaine-alcohol block of the intercostal nerve area in combination with hypodermic administration of morphia in moderate dosage. (*Uglov, F. G.: Some Problems of Cardio-Vascular Surgery, Vestn. Khir. 7: 3, 1956.*)

HEART SURGERY In operations for adhesive pericarditis local analgesia is recommended and if a bilateral pneumothorax should develop, intratracheal anesthesia with controlled respiration. To lessen the hypoxemia, barbiturates and curare-like substances followed by ether-oxygen anesthesia are administered. In cyanotic heart disease hypothermia gives good results. Ninety-six operations upon the heart and pericardium were performed: 10 (no mortality) under local analgesia, 58 (3 deaths) under combined anesthesia, and 28 (8 deaths) under hypothermia. The correct administration of the indicated method of anesthesia has a great influence on the outcome of the operation. (*Uglov, F. G., and others: Anaesthesia for Operations on Heart and Pericardium, Vestn. Khir. 10: 3 1956.*)

OPEN CARDIAC SURGERY Metabolic studies on 120 patients undergoing total body perfusion by means of a bubble oxygenator during open intracardiac procedures have been made. At termination of bypass, arterial *p*H values for all acyanotic patients were within the normal range, while in cyanotic patients the arterial *p*H remained at the control level—somewhat acidotic. However, in these latter patients the preoperative acidotic states were corrected to normal levels 18 hours after surgical repair. A depression of the patients' plasma bicarbonate levels after perfusion was observed in all cases, but this depression was of no greater magnitude than has been observed in surgical patients undergoing minor procedures. Serum potassium levels in the acyanotic patients declined during perfusion, decreased considerably in the immediate postoperative period and then returned to normal within