

group show a severe diffuse pulmonary edema caused or aggravated by anoxic capillary damage and followed by precipitation of fibrin. (*Gruenewald, P.: Significance of Pulmonary Hyaline Membranes in Newborn Infants, J. A. M. A. 166: 621 (Feb. 8) 1958.*)

I.P.P.B. Intermittent positive pressure breathing is used postoperatively for adequate ventilation, for removal of secretions and for aerosol therapy for bronchospasm and infection. Compressed air is preferred to oxygen. Postoperative pulmonary complications are still a major problem following upper abdominal surgery, and are more common in men, in the obese, in smokers and in patients with acute or chronic respiratory infections. (*Noehren, T. H., and others: Intermittent Positive Pressure Breathing (I P P B/1) for Prevention and Management of Postoperative Pulmonary Complications, Surgery 43: 658 (Apr.) 1958.*)

ARTIFICIAL RESPIRATION An S-shaped instrument, one half of which serves as a mouthpiece for the rescuer and the other half as an emergency airway for an apneic patient, can be prepared by the fusion of two Guedel airways at the horizontal rubber disks. Using this device, 87 untrained rescuers were able to produce volumes of tidal air greater than 1500 ml. in anesthetized and curarized apneic volunteers. The mouth-to-airway method has the following advantages over the mouth-to-mouth method: (1) easier maintenance of a patent pharynx; (2) better pulmonary ventilation; (3) less fatigue of the rescuer; (4) less gastric distention. (*Safar, P., and McMahon, M.: Mouth-to-Airway Artificial Respiration, J. A. M. A. 166: 1459 (Mar. 22) 1958.*)

NEWBORN RESUSCITATOR By means of oxygen pressure rapidly changed by a Venturi tube, an electronic timer, and a system of solenoid valves all connected to a heated box-like structure divided into two compartments (by a tight fitting sponge rubber elastic collar) resuscitation was accomplished successfully in all but one of 66 newborns over an 11

month period. The airway was insured by inserting a small oral airway; no endotracheal intubations were necessary. This device was considered safer and more effective than the previously used positive pressure endotracheal resuscitation. (*Lindley, J. E.: New Device for Resuscitation of Newborn, Obst. & Gynec. 11: 176 (Feb.) 1958.*)

INFANT RESUSCITATION The Goddard-Bennett-Lovelace hand resuscitator was used on alternate cases for initiating respiration in 87 newborn infants. When the resuscitator was not used 126 comparable infants received resuscitation by mouth-to-tracheal pressure and other means. Neither term infants nor pre-viable infants benefited from use of the hand resuscitator but premature infants weighing less than 1,000 grams had a definite advantage, with a mortality of only 13 per cent for those treated with the hand resuscitator against 34 per cent among the controls. Although pressures up to 60 cm. water were used no roentgen study disclosed any evidence of pneumothorax or of mediastinal or subcutaneous emphysema. Postmortem examination revealed rupture of the visceral pleura in one infant after 45 minutes of positive pressure with the resuscitator. (*Wilson, M. G., and Roscoe, S. M.: Resuscitation of Newborn Premature Infants, California Med. 88: 312 (Apr.) 1958.*)

PULMONARY EDEMA Ventilatory mechanics were studied in eight patients with frank pulmonary edema. Compliance was found to be only 22 per cent of the average normal value. Resistance was increased over three times the normal value. The highest resistance values were found early in inspiration. It is suggested that bubbles in the alveoli may be responsible for the changes observed. An alternate explanation for these properties may be the elevation of the opening pressures of the terminal lung units. (*Sharp, J. T., and others: Ventilatory Mechanics in Pulmonary Edema in Man, J. Clin. Invest. 37: 111 (Jan.) 1958.*)

HYPOTHERMIA Cardiac output of dogs submitted to hypothermia was in-