of blood by oxygen. The diagram tape is moving at a constant speed; the degree of blood saturation can be determined directly on the scale of the apparatus; it does not suffer from vibrations and shaking and can be used on planes, autocars and in racing. The oxyhaemograph can work for many hours without regulation. (*Kreps, E. M., and others: Self-Recording Cathode Oxyhaemograph, Vopr. Med. Khimii 2: 457 1956.*)

PULMONARY EMBOLISM Symptoms and physical findings associated with fatal pulmonary embolism are (in order of decreasing frequency): tachycardia, cyanosis, dyspnea, tachypnea, diaphoresis, hypotension, cough, rales, hemoptysis and pain. In differentiating massive pulmonary embolism from acute myocardial infarction, it is to be noted that cyanosis is uncommon in myocardial infarction unless cardiac failure supervenes. The combination of restricted activity, fever and tachycardia prior to operation suggests the presence of thrombosis, and in these patients preoperative prophylaxis is of equal importance to postoperative therapy. The use of intravenous infusions in the lower extremities of patients whose activity may be limited postoperatively should be condemned. (*Anderson, M. C., and Shields, T. W.: Significance of Fatal Pulmonary Embolism in Immediate Postoperative Period, J. A. M. A. 167: 422 (May 24) 1958.*)

TRANSFUSION REACTION The use of chlorpheniramine (Chlor-treimeton) in the prophylaxis of pyrogenic reaction to blood transfusion has been studied in 200 blood transfusions. The results of this control study indicate that there is no justification for the routine prophylactic use of an antihistaminic in each bottle of transfused blood in an effort to prevent pyrogenic reaction. These conclusions do not apply in the instance of patients with a known history of allergy. (*Hobsley, M.: Chlorpheniramine Maleate in Prophylaxis of Pyrexial Reactions During Blood Transfusions, Lancet 1: 497 (March 8) 1958.*)

TRACHEOSTOMY IN BRONCHIECTASIS Seven individuals with extensive bilateral bronchiectasis, excessive secretions, and severe pulmonary insufficiency were treated utilizing elective permanent tracheostomy. All patients were supplied with suction apparatus for tracheobronchial aspiration at home. Self aspiration of secretions proved extremely effective in long term management of individuals in whom postural drainage, frequent bronchoscopy, and other treatment had proved inadequate. (*Overhold, R. M., and Segal, M. S.: Long Term Tracheostomy in Extensive Bilateral Bronchiectasis, New England J. Med. 257: 1108 (Dec.) 1957.*)

HEAD AND NECK CANCER In the aged patient the selection of anesthetic agent for head and neck surgery is of the utmost importance. Light anesthesia, adequate blood and electrolyte replacement and the avoidance of unnecessary vasoconstrictors is essential. Inept anesthesia is readily recognized by a prolongation of postoperative recovery. The estimated incidence of carotid sinus reflex difficulties in these patients is 30 per cent. It may be prevented by infiltration of the carotid bulb region with 1 per cent procaine. (*Conley, J. J.: Significance of Cancer of Head and Neck in Aged, Geriatrics 13: 197 (April) 1958.*)

ANESTHESIA FOR T AND A A Magill endotracheal tube fitted with a nasal connecting piece is passed through the mouth and fixed carefully in the midline by strapping below the lower lip. The Boyle-Davis mouth gag is then introduced over the tube. The gag may be opened as wide as required with the surgeon being unaware of the presence of the tube in his field of operation. (*Rotter, K., and Mountford, L.: Airway in Tonsillectomy, Lancet 1: 772 (April 12) 1958.*)

INTESTINAL SURGERY Depth of anesthesia, muscle relaxation, unobstructed airway, hyperpyrexia, shock, hypodrenalism, antihypertensive therapy, abdominal reflexes and hiccups are problems which may occur during gastrointestinal surgery. (*Artusio, J. F., Jr., and Mazzia, V. D. B.: Physiological Problems in Anesthesia During Surgery of Gastrointestinal Tract, Surg. Clin. North America 38: 321 (April) 1958.*)

PYLORIC STENOSIS One hundred and fifty infants were operated upon for hypertrophic pyloric stenosis. The method of anesthesia in 142 of these was with local