anesthesia, using 0.25 per cent lidocaine with epinephrine. The nerves to the right upper rectus muscle were blocked bilaterally, using a total of 12 ml. of solution. Two infants had convulsions when larger amounts were injected. There were no deaths in the series. (*Leatherdale, R. A. L.: Anaesthesia for Rammstedt's Operation, Lancet : 932 (May 3) 1958.*)

ADRENALECTOMY Anesthetic premedication for this procedure consisted of pentobarbital, meperidine and atropine. Induction with thiopental sodium and tubocurarine was followed by endotracheal intubation, and maintenance was with nitrous oxide, oxygen and ether. An internist supervised preoperative and postoperative cortisone medication, and intravenous hydrocortisone was available in operating and recovery rooms. (*Junker, B. J., and others: Anesthesia for Adrenalectomy, J. A. M. A. 166: 1824 (April 12) 1958.*)

PORPHYRIA Porphyria is a dominant non-sex linked defect in porphyrin metabolism with increased urinary excretion of uroporphyrin and coproporphyrin. These substances produce reddish black color of urine, particularly evident if urine has been exposed to sunlight. Symptoms are varied but prominently include abdominal pain, central and peripheral neuropathy with psychotic behavior. Acute exacerbations of the disease related to barbiturate administration, alcohol ingestion and surgery. Mortality in an acute attack may vary from 50 to 90 per cent. (*Seide, M. J.: Porphyria: Report of Nine Cases Diagnosed in Hartford Area, Including Family with Three Affected Members, New England J. Med. 258: 630 (March) 1958.*)

INTUBATION GRANULOMA In spite of all measures of prophylaxis against laryngeal granuloma, the lesion may nevertheless occur and this occurrence does not necessarily reflect unfavorably on the anesthesiologist. One of the commonest causes of litigation in these cases is unwise management of the lesion or neglect by the anesthesiologist to visit the patient postoperatively. Removal of the granuloma is not necessary unless the lesion interferes with respiration and phonation. Rather, the treatment of choice is strict voice rest without surgery; the polyp will eventually be ejected by self amputation. The anesthesiologist can protect himself against lawsuit by close postoperative follow-up. Hoarseness, dysphonia or persistent sore throat indicates the need for immediate consultation by a laryngologist. Special precaution should be exercised in the case of the patient who uses his voice professionally or who has had previous laryngeal surgery. (*Barton, R. T.: Medicolegal Aspects of Intubation Granuloma, J. A. M. A. 166: 1821 (April 12) 1958.*)

TRACHEAL OBSTRUCTION Tracheal obstruction was caused by a subglottic, submucosal, tracheal hemangioma in a one month old infant. The hemangioma was not grossly apparent by either laryngoscopy or bronchoscopy. Review of literature and of this case indicates diagnosis of this lesion is difficult and that it may be a frequent cause of intermittent tracheal obstruction in infants under one year of age. Irradiation preceded by tracheotomy is recommended as treatment of choice. (*Doermann, P., Lunseth, J., and Segnitz, R. H.: Obstructing Subglottic Hemangioma of the Larynx in Infancy, New England J. Med. 258: 68 (Jan.) 1958.*)

MUSCULAR DYSTROPHY Twelve patients with muscular dystrophy were studied by right heart catheterization and electrocardiography. Tachycardia was noted in ten patients, and eight of the twelve had abnormal QRS complexes in the electrocardiogram. The data from this study supports the possibility that some of these patients were on the verge of congestive heart failure. They did not pass into frank failure because of the limited demands placed on their circulation. There was no pulmonary hypertension in this group. (*Gailani, S., and others: Muscular Dystrophy Catheterization Studies Indicating Latent Congestive Heart Failure, Circulation 17: 583 (April) 1958.*)

TETANUS A 43-year-old woman developed severe tetanus following a left pulmonary lobectomy. Her course was complicated by bronchiectasis, empyema, bronchopleural fistula, and peripheral circulatory failure. Her disease was successfully treated with antitoxin, antibiotics, tubocurarine, and intermittent positive pressure respiration. She required the full time attention of anesthetists for three