poxia. (*Shev, E. E., and Robinson, S. J.: Electroencephalographic Findings Associated with Congenital Heart Disease, Electroencephalog. & Clin. Neurophysiol. 10: 253 (May) 1958.*)

XYLOCAINE Xylocaine is a member of a new group of anaesthetic agents. Its active principle gramine was isolated from grasses growing in central Asia. In 1946 xylocaine was synthesized by the Swedish chemists Lofgren and Lundquist. In the body it undergoes slow decomposition, mainly in the liver. It shows a greater affinity towards sensory nerve fibers than to motor or sympathetic nerves. Xylocaine lowers the arterial pressure and is an effective local anesthetic. Its main advantage over procaine is that anesthesia commences sooner and lasts longer. The maximum permissible dose of xylocaine is 0.2 Gm. In case of overdose oxygen should be administered and artificial respiration performed. To increase the arterial pressure, intravenous ephedrine is advised. The use of xylocaine as a local anesthetic by the method of creeping infiltration produces excellent analgesia. (*Bantsekina, M. M., and Kudryavtseva, A. M.: Anesthetic Properties of Xylocaine, Eksper. Khir. 5: 32, 1956.*)

SUBARACHNOID BLOCK Careful selection of patients with intractable pain, rigid technique of needle placement and neurological evaluation before and after blocks make subarachnoid alcohol blocks useful in malignant disease. Repeat blocks are necessary if the first block fails to eliminate the pain, if the pain is bilateral or if the block wears off. It is especially useful in patients with a short life expectancy and should be supplemented with tranquilizers or sedatives. (*Perese, D.: Subarachnoid Alcohol Block in Management of Pain of Malignant Disease, A. M. A. Arch. of Surg. 76: 347 (Mar.) 1958.*)

HEPARINIZED BLOOD The severe and occasionally fatal shock syndrome observed when citrated blood is used for exchange transfusion does not occur when heparinized blood is used straight from the donor. (*Valentine, G. H.: Exchange Transfusion in Newborn Using Heparinized Blood, Canad. M. A. J. 78: 977 (June 15) 1958.*)

OVERTRANSFUSION Circulatory overloading is now probably the most common cause of death from blood transfusion when proper methods are employed to prevent incompatibilities. Overtransfusion can be clinically noted by the appearance within an hour of dyspnea, orthopnea, intense cyanosis, blood-tinged frothy sputum, venous engorgement, sibilant and sonorous râles and often acute auricular fibrillation. Prophylaxis is the best treatment. Active treatment should be prompt and consist of (1) use of extremity tourniquets, (2) phlebotomy, (3) positive pressure oxygen therapy, (4) restriction of fluid intake. (*Downs, J. W.: Problem of Overtransfusion in Massive Hemorrhage, Ann. Surg. 148: 73 (July) 1958.*)

MASSIVE AIR EMBOLISM Massive air embolism (approximately 300 cc. within a few seconds) occurred in a patient momentarily left unattended during the administration of blood under positive pressure. Cardiac and respiratory arrest occurred within 15 seconds. Essential steps in the treatment of this catastrophe are: (1) Withdraw the infusion needle and discontinue the source of the air embolism. (2) Place the patient in Trendelenburg position to prevent air from entering the cerebral circulation in the event that arterial embolism may have occurred. (3) If time permits, place the patient in the left lateral position so that the air block (of the pulmonary valve) may be released. (4) If cardiac arrest occurs or the air embolism is too massive for the previous maneuver to succeed, perform emergency thoracotomy with needle aspiration of the right ventricle followed by cardiac massage. (5) Maintain a clear airway and provide effective artificial respiration with oxygen. (*Shires, T., and O'Banion, J.: Successful Treatment of Massive Air Embolism Producing Cardiac Arrest, J. A. M. A. 167: 1483 (July 19) 1958.*)

TRANSFUSION REACTION A total of 191 transfusions of 15–20 ml. of incompatible blood was administered. To 123 of these a ganglion-blocking agent was