agement of Blood Loss Anemia, Surg., Gynec. & Obst. 106: 734 (June) 1958.)

NORADRENALINE A man in shock from myocardial infarction was treated with an intravenous infusion of noradrenaline 1:100,000. The blood pressure responded to this treatment and was maintained at about 110/70 for 68 hours after which the pressor drug was not required. A total of 44 mg. of norepinephrine was infused. From the fourth to the sixth day after admission, patches of gangrene appeared on both hands and both feet. Thereafter, gangrene developed in both midforearms and both midcalfs. The patient died 14 days after admission. *(Greenbaum, D.: Gangrene of the Extremities Following Cardiac Infarction and Noradrenaline Therapy, Lancet 1: 1103 (May 24) 1958.)*

ANESTHESIA MACHINE A new midget portable model anesthesia machine, oxygen inhalator and resuscitator is now available. Anesthesia can be induced quickly and maintained for periods of 3 to 20 minutes in obstetric, pediatric, dental and traumatic cases by administering a nonexplosive mixture of 40 per cent cyclopropane, 30 per cent oxygen and 30 per cent helium from thumb-sized cylinders. Resuscitation and brief periods of oxygen therapy can be accomplished by using the small (3,400 cc.) 100 per cent oxygen cylinders. The machine is easily refilled or disassembled for cleaning, and its miniature size permits it to be conveniently carried in a physician's satchel. *(Hingson, R. A.: Western Reserve Anesthesia Machine, Oxygen Inhalator and Resuscitator, J. A. M. A. 167: 1077 (June 28) 1958.)*

BLUE CROSS While approving rate increases for Pennsylvania Blue Cross plans, the State Insurance Commissioner ruled that the Blue Cross plans must solicit assistance of hospitals, hospital councils, and other interested persons in exploring all areas to determine where economies can be made. He based his ruling on testimony obtained during an eighteen-day hearing in which abuses of Blue Cross plans were brought out. *(State Seeks to Regulate Hospital Costs, Mod. Hosp. 90: 51 (June) 1958.)*

BRACHIAL PLEXUS BLOCK During the supraclavicular brachial plexus block: (1) The anesthesiologist should stand at the patient's head. This position is suitable for repeated blocks if necessary during surgery. (2) The needle should be inserted at the midpoint of clavicle just lateral to the subclavian artery. When properly placed the needle is "rocked" by the arterial pulsations. (3) Nesacaine is the anesthetic agent preferred, 1 per cent for selective sensory anesthesia and 2 per cent for sensory and motor anesthesia. *(Ansbro, F., and others: Brachial Plexus Block, Am. J. Surg. 95: 953 (June) 1958.)*

INTRAOSSEOUS ANESTHESIA A total of 92 reductions were performed. To the forearm or thigh a rubber bandage was applied, if possible with the limb elevated. The anesthetic was injected through a special needle into the spongiosa at a depth of 0.5-1 cm.; for anesthesia of the forearm and hand, 15–22 ml. of a 2 per cent solution of novocaine was used, and for anesthesia of the leg, 25–30 ml. The injection sites used were the olecranon process, the distal epiphysis of the bones of the forearm, the medial condyle of the tibia and the calcaneus. Anesthesia developed after 7–12 minutes. There were no complications. This method can be used irrespective of the length of time after injury. *(Abramov, Y. G.: Intraosseous Local Anaesthesia in Treatment of Closed Fractures of Bones of Limbs, Nov. Khir. Arkh. 5: 29 1956.)*

TOPICAL ANESTHESIA Chilling the skin with an ice cube of 1:1,000 aqueous Zephiran gives quick, painless, superficial anesthesia plus antisepsis. *(Zimmerman, M. C.: Anesthesia and Antisepsis with Benzalkonium Chloride (Zephiran) Ice Cubes, A. M. A. Arch. Dermat. & Syph. 77: 122 (Jan.) 1958.)*

OBSTETRIC ANESTHESIA If good anesthesia service is going to be rendered to the more than four million mothers giving birth in the United States each year, better cooperation is needed between

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obstetricians and anesthesiologists. The field of analgesia during labor must be shared, the anesthesiologist must receive information concerning the patient's condition, and the anesthesiologist must be called soon enough to allow familiarity with the patient and her problems. (*Rhu, H. S., Jr.: Editorial—Obstetric Anesthesia, Obst. & Gynec. 11: 728 (June) 1958.*) (*Abstractor's note: A general acceptance by obstetricians of the enlightened attitude expressed by this editorialist would alleviate a large number of the problems encountered by many anesthesiologists in their relations with obstetrical services.*)

PITOCIN OVERDOSAGE A term primigravida who had just received spinal anesthesia for delivery mistakenly received 1 cc. of Pitocin in place of the 50 mg. of Demerol ordered. Tetanic uterine contractions were blocked by open-drop ether anesthesia carried to plane two of stage three. Epinephrine might also have inhibited the myometrium but it would have added the risk of cardiac arrhythmia. Delivery was accomplished without incident. (*Watrous, J. B., Jr., and others: Pitocin Overdosage in First Stage of Labor, Obst. & Gynec. 11: 665 (June) 1958.*)

SPINAL AGENTS Although nupercaine spinal anesthesia produces a long block, anesthesia is often inadequate necessitating supplementary anesthesia. One hundred patients who received Xylocaine were compared with 100 patients who received nupercaine for spinal anesthesia for vaginal deliveries. Xylocaine was completely adequate in 92 per cent of the cases as compared to 48 per cent for the nupercaine series. (*Phillips, O. C., and others; Spinal Anesthetic Agents for Vaginal Delivery, Obst. & Gynec. 11: 680 (June) 1958.*)

NEWBORN BLOOD OXYGEN A group of fifteen newborn infants whose mothers received oxygen through a BLB mask prior to delivery had considerably higher average partial pressure of oxygen in the umbilical vein blood compared with infants whose mothers did not receive oxygen. Whether the administered oxygen benefited the newborn child is difficult to answer. (*McClure, J. H.: Newborn Blood Oxygen, Obst. & Gynec. 11: 696 (June) 1958.*)

OBESITY In a study of 747 parturients weighing two hundred pounds or more, an increased incidence of toxemia of pregnancy and chronic hypertensive disease of pregnancy was found. Obese patients tended to have large babies often necessitating cesarean section. They had a high incidence of spontaneous, uncomplicated, unsterile deliveries without anesthesia. Conduction anesthesia was infrequently used usually because of associated technical difficulties. (*Witten, S. B.: Labor in Obese Patient, Obst. & Gynec. 12: 99 (July) 1958.*)

OBSTETRIC ANESTHESIA Occurrence of cardiac arrest during an otherwise uncomplicated vaginal delivery under cyclopropane anesthesia stresses the importance of the presence of an anesthesiologist in delivery rooms, as well as having available all equipment necessary to cope with this emergency. (*McBurney, R. D.: Cardiac Arrest: Case Report, West. J. Surg. 66: 150 (May–June) 1958.*)

PORPHYRIA Experience with porphyria in pregnancy emphasizes the avoidance of barbiturates, alcohol, and intravenous barbiturate anesthesia. In these cases chlorpromazine has been used successfully for sedation, and spinal anesthesia for surgery. (*Neilson, D. P., and Neilson, R. P.: Porphyria Complicated by Pregnancy, West. J. Surg. 66: 133 (May–June) 1958.*)

INFANT RESUSCITATION There is at present no recognized method of artificial respiration which is effective in securing adequate tidal exchange in the apneic infant other than positive/negative pressure though a mask or endotracheal tube. (*Editorial: Morbid Anatomy and Function in Infant Lungs, Canad. M. A. J. 79: 47 (July 1) 1958.*)

The "Briefs" of Russian literature were taken from *Excerpta Medica's* "Abstracts of Soviet Medicine," which is supplied through the Public Health Service of the National Institute of Health.

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