

shed) and increase of the P wave (in 13 cases) are also often shown in the esophageal lead. (Maslyuk, V. I.: *Oesophageal ECG Lead in Hypertensive Disease, Klin. Med. (Moskva)* 1: 98, 1958.)

BRONCHOSCOPY Bronchoscopy can be performed easily and atraumatically by the novice if the upper respiratory tract and larynx is first anesthetized and a nasotracheal catheter passed blindly. After the tracheobronchial tree is anesthetized via the catheter the bronchoscope is passed in the usual manner using the catheter as a guide. (Thomas, D. E.: *Bronchoscopy Made Easy, Amer. Rev. Resp. Dis.* 82:1 (July) 1960.)

POSTOPERATIVE PSYCHOSIS In the majority of 24 postoperative patients, the psychic disorder (alimentary-delirious, hallucinatory-paranoid syndromes, residual delirium, etc.) developed acutely on the second to fourth day after operation and lasted for several days to 2 months. In all cases the main cause of the psychosis was the surgical operation, as both severe psychic and physical trauma. The necessity is stressed of taking into consideration the personality and the psychic make-up of the patient in the pre- and postoperative period. The subsequent following of a protective regime and the establishment of contact between patient and surgeon are of great importance. The widespread use of chlorpromazine (1-2 ml. of a 2.5 per cent solution intramuscularly or 50 mg. internally) in surgical practice is necessary. Chlorpromazine has a general tranquilizing action and will prevent the development of postoperative psychoses. (Shabanov, A. N., Tschibeev, B. A., and Sharipova, S. A.: *Psychic Disturbances Associated with Surgical Operations, Sov. Med.* 1: 64, 1959.)

SCIATIC NERVE INJURY Serious sciatic nerve injury can result from injections of commonly used antibiotics and other agents into the buttock, especially in infants and young children. The usual presenting complaint is paralytic foot drop, but this is frequently misdiagnosed as a congenital lesion or the result of unrecognized poliomyelitis. Diagnosis is confirmed by the demonstration

of sensory loss and anhydrosis over the distribution of sciatic nerve branches. Surgical exploration of the buttock reveals marked scarring in and about the sciatic nerve. Recovery is poor in this important, preventable type of peripheral nerve injury which probably occurs more commonly than is usually supposed. The preferred site of injection, when the intramuscular route must be used, should be the mid-anterior aspect of the thigh, with the quadriceps muscle as the recipient area. This affords a greater muscle mass than the relatively small area of the upper outer gluteal quadrant. (Combes, M. A., and others: *Sciatic Nerve Injury in Infants, J.A.M.A.* 173: 1336 (July 23) 1960.)

EPIGLOTTITIS Epiglottitis in children is generally abrupt in onset and often progresses from the first symptoms to a fatal respiratory obstruction in four to six hours. The respiratory difficulty is chiefly inspiratory obstruction, although expiratory stridor is also present, particularly if the larynx is involved. There is no true hoarseness, the characteristic sound of the voice being described as "muffled." Frequent swallowing motions are present, and the patient may gag and vomit. The patient exhibits the classic signs of air hunger. The epiglottis is greatly enlarged, with intense redness and edema. If complete airway obstruction occurs, placement of a large intravenous needle (13 or 15 gauge) into the trachea or sublingual area will probably maintain a life-sustaining airway until definitive therapy can be established. Relief of the respiratory obstruction is the prime objective of therapy, and early tracheotomy is frequently indicated. (Vetto, R. R.: *Epiglottitis, J.A.M.A.* 173: 990 (July 2) 1960.)

HYPGLOSSAL PARALYSIS Endotracheal anesthesia of more than five hours for correction of aortic isthmus stenosis with the patient in right lateral position was followed by paralysis of the recurrent laryngeal and hypoglossal nerves. The surgery might have contributed to the paralysis of the recurrent nerve but pressure of the endotracheal tube is believed to have been responsible for the damage to the hypoglossal nerve. There was gradual recovery of all symptoms. (Konrad,