

with cortisone alone or cortisone plus desiccated thyroid. The adequacy of hormonal therapy may be evaluated by this method. (Kosowicz, J., and Roguska, J.: *Electrocardiogram in Hypopituitarism, Reversibility of Changes During Treatment*, *Amer. Heart J.* 65: 17 (Jan.) 1963.)

ATROPINE No aspect of anesthesia, within the memory of the present generation of anesthesiologists, has been as unquestioned as the preoperative use of a belladonna derivative. However, atropine upsets the autonomic balance of the body. As a result sympathetic tone predominates. The absence of profuse oral and pharyngeal secretions when giving open-drop ether is almost mandatory, but at other times the problem is not salivation but too much drying. Often the patient's chief complaint on arriving in the operating theater is parched lips, mouth, and throat, and many a sore throat in the postoperative period can be traced to this dry state. The use of atropine in a routine manner would seem undesirable. The drug should be reserved for particular purposes, as for example to block the carotid sinus reflex or to prevent Stokes-Adams attacks. (Holt, A. T.: *Premedication with Atropine Should Not be Routine*, *Lancet* 2: 984 (Nov. 10) 1962.)

PROCAINE-ACETYLCHOLINE ANTAGONISM Depression in action potential induced by procaine can be arrested or even reversed by acetylcholine in the frog sciatic single nerve preparation. Extent and time of the reversal are related to relative concentrations of both agents and to duration of previous procaine exposure. Resting membrane potential is not affected. Repeated exposures to procaine are characterized by increasingly rapid onset of block, reduced susceptibility to acetylcholine competition, and failure of com-

plete recovery after removal of procaine. Time parameters of recovery from procaine depression are independent of previously applied concentrations of either acetylcholine or procaine. Since acetylcholine has been shown not to cross the nerve membrane, the results are interpreted as indicating that the receptor involved in the competition exists on the external surface of the membrane. (Bloom, F. E., and Schoepfle, G. M.: *Kinetics of Procaine-Acetylcholine Antagonism*, *Amer. J. Physiol.* 204: 73 (Jan.) 1963.)

PNEUMOTHORAX In 200 consecutive surgical patients, in whom intercostal nerve block constituted a part or all of the anesthetic procedure, anteroposterior roentgenograms of the chest were taken prior to the block and on the second postoperative day. A total of 2,610 intercostal nerves were blocked by 12 physicians. The incidence of silent pneumothorax was 0.42 per cent. No instance of symptomatic pneumothorax occurred in this series, and in a previous series the incidence was only 0.092 per cent. Although symptomatic pneumothorax requires vigorous therapy, viz., removal of air and drainage of fluid from the chest cavity, no treatment for silent pneumothorax was necessary other than watchful waiting. Routine chest roentgenograms prior to and following intercostal nerve block are not indicated; and the possibility that a pneumothorax may occur is not a substantial argument against general routine employment of intercostal nerve block for anesthesia or therapy. Its use in the control of postoperative pain and the pain from fractured ribs is particularly valuable in that it allows early ambulation, change in position, deep breathing, and coughing. (Moore, D. C., and Bridenbaugh, L. D.: *Pneumothorax, Its Incidence Following Intercostal Nerve Block*, *J.A.M.A.* 182: 1005 (Dec. 8) 1962.)

