

12. Katz, R. L., Gissen, A. J., and Karis, J. H.: Effects of hexafluorenum and edrophonium on the neuromuscular blocking action of succinylcholine, decamethonium, imbretil and d-tubocurarine, *ANESTHESIOLOGY* 26: 154, 1965.
13. Wretling, A., and Wåhlin, Å.: The effect of succinylcholine on the orbital musculature of the cat, *Acta Anaesth. Scandinav.* 3: 101, 1959.
14. Wynands, J. E., and Crowell, D. E.: Intraocular tension in association with succinylcholine and endotracheal intubation: A preliminary report, *Can. Anaes. Soc. J.* 7: 39, 1960.
15. Lewallen, W. M., Jr., and Hicks, B. L.: The use of succinylcholine in ocular surgery. *Amer. J. Ophthalm.* 49: 773, 1963.
16. Craythorne, N. W. B., Rottenstein, H. S., and Dripps, R. D.: The effects of succinylcholine on intraocular pressure in adults, infants and children during general anesthesia, *ANESTHESIOLOGY* 21: 59, 1960.
17. Matyushkin, D. P.: Phasic and tonic neuromotor units in the oculomotor apparatus of the rabbit, *Sechenov Physiol. J. USSR* 47: 65, 1961.
18. Hess, A., and Pilar, G.: Slow fibers in the extraocular muscles of the cat, *J. Physiol.* 169: 780, 1963.
19. Katz, R. L., and Eakins, K. E.: The effects of succinylcholine, decamethonium, hexacarbacholine, gallamine and dimethyl tubocurarine on the twitch and tonic neuromuscular systems of the cat, *J. Pharmacol. Exp. Therap.* 154: 303, 1966.
20. Bach-y-Rita, P., and Ito, F.: In vivo studies on fast and slow muscle fibers in cat extraocular muscle, *J. Gen. Physiol.* 49: 1177, 1966.
21. Sanghvi, I. S.: Stimulation of mammalian extraocular muscle by cholinomimetics, Ph.D. Thesis. University of Illinois, 1966.
22. Dieter, S. E.: The demonstration of different types of muscle fibers in human extraocular muscle by electron microscopy and cholinesterase staining, *Invest. Ophthalm.* 4: 51, 1965.
23. Drucker, A. P., Sadove, M. S., and Unna, K. R.: Ophthalmic studies of curare and curare-like drugs in man, *Amer. J. Ophthalm.* 34: 543, 1951.
24. Sobel, A. M.: Hexafluorenum, succinylcholine, and intraocular tension, *Anesth. and Analg. Curr. Res.* 41: 399, 1962.

Surgery

SURGICAL RISK IN LUNG DISEASE Preoperative assessment of pulmonary disease is essential to estimate properly the patient's chances of survival from major surgery. Almost all patients will tolerate operative intervention if adequate ventilatory assistance is provided. Postoperatively, in both obstructive and restrictive lung disease, adequate spontaneous ventilation may be difficult to achieve if the supine position must be used. Therapy postoperatively may include mechanical ventilation and measures to liquify secretions. Steroids may be extremely helpful in the severe asthmatic, both to liquify secretions and relieve bronchospasm. (Olsen, A. M.: *Evaluation of Surgical Risk in Patients with Chronic Obstructive Lung Disease and other Respiratory Handicaps*, *Med. Clin. N. Amer.* 51: 341 (March) 1967.)

CAROTID SURGERY Patients with transient cerebral ischemia or asymptomatic carotid stenosis are the best candidates for carotid surgery. Operative mortality has been reduced to 1 per cent with use of internal shunts and modification of anesthetic technique. At the start of anesthesia, the patient is given 10 mg. of dexamethasone to protect against cerebral edema. Before arteriotomy, 5,000 units of heparin are given. The CO₂ absorber is turned off to increase cerebral blood flow and elevate jugular venous blood P_{CO₂} and P_{O₂}. Frequent extrasystoles, attributed to excessive elevation of CO₂, are an indication to turn in the soda lime again. The blood pressure is not permitted to fall below normal at any time, phenylephrine being used if necessary. (Movicus, H. J., Zuber, W. F., and Gaspar, M. R.: *Carotid Thromboendarterectomy*, *Arch. Surg.* 94: 585 (May) 1967.)