

rhage was stopped by inflating the balloon of the tracheotomy tube. Transthoracic ligation of the vessel was then accomplished, and the patient survived. (Reich, M. P., and Rosenkrantz, J. G.: *Fistula Between Innominate Artery and Trachea*, Arch. Surg. 96: 401 (March) 1968.)

LARYNGOTRACHEAL TRAUMA Injury to the structures of the neck has become more important because of the massive soft-tissue trauma caused by high-velocity bullets. The establishment of an airway takes first priority. One must consider the associated problems: fracture of the spine; fractures of the laryngeal and tracheal cartilages; the presence of easily-dislodged sharp foreign bodies which may move down a bronchus or start fresh bleeding; and the possibility of other severe injuries. In the haste to establish an airway, one should not produce complications of other types. (Yarington, C. T.: *Immediate Repair of Blunt and Penetrating Trauma to the Larynx and Trachea*, Arch. Surg. 96: 403 (March) 1968.)

HYPOXEMIA IN BRONCHIAL ASTHMA Forty-one patients in status asthmaticus had hypoxemia without hypercapnia and, in addition, had severe obstructive and restrictive ventilatory impairment. The extent of hypoxemia was closely related to forced vital capacity (FVC) and not at all to one-second forced expiratory volume (FEV₁). (FVC measures specifically restrictive, and FEV₁ specifically obstructive, ventilatory impairment). Reduced compliance, as a result of hyperinflation, is more important in leading to ventilation/perfusion imbalance in asthma than increased airway resistance. (Palmer, K. N. V., and Diamant, M. L.: *Hypoxemia in Bronchial Asthma*, Lancet 1: 318 (Feb.) 1968.)

EPINEPHRINE IN BRONCHIAL ASTHMA In 15 asthmatic patients, epinephrine relieved airway obstruction but not hypoxemia. In a similar group of asthmatic patients, voluntary hyperventilation produced a transient increase in PaO₂, whether or not air-

way obstruction was relieved. Although epinephrine may produce transient stimulation of ventilation and relief of airway obstruction, hypoxemia, which is related to disturbed ventilation-perfusion relationships, often persists. (Ress, H. A., Millar, J. S., and Donald, K. W.: *Adrenaline in Bronchial Asthma*, Lancet 2: 1164 (Dec.) 1967.)

AMINOPHYLLINE IN BRONCHIAL ASTHMA Aminophylline given to nine asthmatic patients relieved airway obstruction but had an unpredictable effect on PaO₂. In many cases, the existing hypoxemia was worsened. Changes in PaO₂ seemed to be related to changes in ventilation-perfusion relationships. When aminophylline is administered to patients in whom arterial oxygen tension is already decreased, the concentration of inspired oxygen should be raised. (Ress, H. A., and others: *Aminophylline in Bronchial Asthma*, Lancet 2: 1167 (Dec.) 1967.)

POSITION AND VENTILATION In an aged patient with emphysema, respiratory complications might be expected to develop following perineal prostatectomy with the patient under spinal anesthesia in the exaggerated lithotomy (Young's) position. Complications have failed to occur at the expected rate, prompting a study of ventilation in the exaggerated lithotomy position. Nine control subjects demonstrated reductions in timed forced vital capacity (FVC) and forced expiratory volume (FEV 0.5 second) similar to those previously reported for healthy volunteers in the lithotomy position. Eighteen urological patients with pulmonary disease manifested in reduced FVC and FEV 0.5 second were studied before and during spinal anesthesia. They had no change in the FVC, but an improved FEV 0.5 second in the exaggerated lithotomy position. The weight of the viscera and thighs probably acts to elevate the end-exhalational position of the diaphragm and adds force to the maximum expiratory effort. (Giesecke, A. H., Jr., and others: *The Prostate, Ventilation, and Anesthesia*, J.A.M.A. 203: 389 (Feb.) 1968.)