

# Literature Briefs

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## Obstetrical Anesthesia

**ATROPINE AT DELIVERY** Effects of atropine sulfate and atropine methylbromide on maternal and fetal heart rates were observed in 12 women at term. Both drugs were given in graded doses to a total dose of 0.8 mg/70 kg body weight. Both drugs caused significant acceleration of the mothers' heart rates, but only atropine sulfate accelerated fetal heart rates. Atropine methylbromide, because of its charge, probably did not penetrate the placental barrier as readily as atropine sulfate. (dePadua, C. B., and Gravenstein, J. S.: *Atropine Sulfate vs Atropine Methyl Bromide. Effect on Maternal and Fetal Heart Rate*, J.A.M.A. 208: 1022 (May) 1969.)

**OBSTETRIC CAUDAL ANESTHESIA** A series of 10,007 single-injection caudal anesthetics were administered for vaginal delivery in a large private hospital. The use of caudal anesthesia increased from about 12 to 78 per cent of all anesthetics during an eight-year period, indicating satisfaction of patients, obstetricians, and anesthesiologists with this technique. Single-injection caudal anesthesia was satisfactory in 95 per cent of patients who received it; 5 per cent of patients were denied this anesthetic because of problems with needle placement. The usual contraindications to caudal anesthesia were observed. Apgar scores were not different in infants delivered with caudal, spinal, or local anesthesia. Approximately 0.1 per cent of patients developed convulsions; 5 per cent became hypotensive. No maternal or fetal deaths were thought to be related to this anesthetic technique. (Epstein, H., and Sherline, D.: *Single Injection Caudal Anesthesia in Obstetrics*, *Obstet. Gynec.* 33: 496 (April) 1969.)

**RESUSCITATION OF THE NEWBORN** Twenty-eight newborn infants whose Apgar scores did not improve during five minutes of standard resuscitation were placed in cold water and artificially ventilated. Eight weighed less than 2,500 g, while the remainder weighed between 2,500 and 4,499 g. During exposure to cold there was a mean increase of 6.4 Apgar units, and all infants began to breathe. The infants were then allowed to rewarm slowly. Three deaths occurred; two premature infants died of respiratory failure; the third, a full-term infant, had congenital cardiac anomalies. Hypothermia did not appear to contribute to the three deaths. Cooling the infants increased the Apgar scores, even for those with zero ratings. Hypothermia may be a valuable adjunct in resuscitation of the asphyxiated neonate. (Dunn, J. M., and Miller, J. A.: *Hypothermia Combined with Positive Pressure Ventilation in Resuscitation of the Asphyxiated Neonate*, *Amer. J. Obstet. Gynec.* 104: 58 (May) 1969.)