

## CONCLUSION

This technique allows warm fresh unanticoagulated adult whole blood to be rapidly transfused in situations requiring massive blood replacement. Blood transfused by means of incremental transfusion of warm unanticoagulated adult blood is as nearly normal, in terms of metabolic physiology and factors necessary for normal clotting, as it is possible to obtain. Therefore, it is effective in preventing (or treating) complications associated with massive transfusion of bank blood in small infants.

## REFERENCES

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## Surgery

**MEDIASTINOSCOPY** Positive diagnostic results were obtained in 13 of 32 patients who underwent mediastinoscopy. Although local anesthesia may be used, general anesthesia with tracheal intubation improves the accuracy and safety of the procedure. Any severe systemic disease or any disease that would preclude anesthesia is a contraindication to mediastinoscopy. Complications of mediastinoscopy include hemorrhage, air embolism, vocal-cord paralysis, pneumothorax, mediastinitis and tracheal injury. (Cooley, J. E., and Houseworth, J. H.: *Mediastinoscopy: Indication, Technique and Results, Papers of Carle Clinic and Foundation* 23: 3 (Jan.) 1970.)

**FUTURE OPERATING ROOMS** In the new surgical complex at Illinois Masonic Medical Center in Chicago, a patient scheduled for elective surgery will have routine preoperative preparation as an outpatient and will be admitted directly to one of the preoperative beds the night before operation, rather than being assigned to a regular bed in the hospital. The day of operation, the patient will be transported to a holding area, from which he will subsequently enter the operating suite through the "front" access door. The staff—surgeons, surgical nurses, anesthesiologists, and orderlies—will enter their shower-locker-lounge area on the third floor, dress for surgery, exit to a common vestibule and then to a staircase which serves the third- and second-floor clean core only, and finally will enter the operating suite through its "back" door. Ten of the operating rooms will be fitted with floor pedestals located close to the table, eliminating the usual tangle of cords and hoses. These pedestals will contain nonflammable gases, physiologic monitoring devices with leads to a remote master screen, electrocautery equipment with remote control, water, compressed air, and electrical power with standard voltage. None of these rooms will require conductive flooring or explosion-proof outlets, since no flammable gases will be used in them. The few remaining rooms will be fitted in the conventional manner for teaching and research purposes. At the end of each work day, all large equipment such as tables, tray stands, etc., will be disinfected in the operating room and moved to a station in the outer-ring corridor, where the equipment will be washed with decontaminant. Detailed planning has gone into the systems for ventilation, equipment supply, waste disposal, and communications and into the design for the recovery room and intensive care units. (Hix, A. M., and Beck, R. M.: *Surgeries for the 1970's, Mod. Hosp.* 114: 85 (Jan.) 1970.)