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Drugs

HYPERTENSIVE PATIENTS Anesthesia and operation are definite dangers to the patient with arteriosclerotic disease of the central nervous system, the kidney, and the heart; in the presence of unsuspected pheochromocytoma; in malignant severe hypertension; to the patient receiving unknown potent antihypertensive medication. A patient who has had a stroke should be regarded as one with a myocardial infarction and not receive elective operative until the clinical course has been stable for six months to two years after the thrombosis. Diagnosis of the cause of hypertension should be attempted before operation, to rule out a pheochromocytoma. Diuretics lead to hypokalemia. Monamine oxidase inhibitors inactivate and rauwolfia alkaloids deplete catecholamines in the tissues. Ganglionic blocking drugs inhibit parasympathetic as well as sympathetic actions. Preoperative treatment of hypertension should be continued in those patients who: require large doses of potent antihypertensive drugs; have severe hypertensive disease as evidence by retinal changes; have diastolic pressures of 140 mm Hg; have vascular deterioration in the heart, brain, and kidney. The safest drugs for use before operation are those with short durations of action, such as alpha-methyldopa, hydralazine, and ganglionic blocking agents. (Breslin, D. J., and Swinton, N. W., Jr.: *Elective Surgery in Hypertensive Patients—Preoperative Considerations*, *Surg. Clin. N. Amer.* 50: 585 (June) 1970.)

SURGICAL RISK OF CARDIAC PATIENTS Risk of surgery in patients with rheumatic, hypertensive, or congenital heart disease seems proportional to the functional cardiac status. However, severe coronary disease may exist with few clinical symptoms or abnormal laboratory studies. Only a few disorders of the heart directly cause death: arrhythmias, congestive failure, and cardiogenic shock. Tests useful in determining risk include an exercise electrocardiogram, measurement of central venous pressure and circulation time, a three-hour oral glucose-tolerance test, and arterial blood gases and pH. Maximal expiratory flow rates and timed vital capacities are simple useful screening tests of pulmonary function. The surgical risk in patients who have had myocardial infarctions exceeds that of the general population for two or three years after infarction. (Alexander, S.: *Surgery in the Cardiac Patient*, *Surg. Clin. N. Amer.* 50: 567 (June) 1970.)