to the Lee-White coagulation time. Am J Clin Pathol 50: 403–407, 1968
6. Jaberi M, Bell WR, Benson DW: Control of heparin therapy in open-heart surgery. J Thorac Cardiovasc Surg 67:133–141, 1974
7. Reno WJ, Rotman M, Grumbine FC, et al: Evaluation of the BART test (a modification of the whole-blood activated recalcification time test) as a means of monitoring heparin therapy. Am J Clin Pathol 61:78–84, 1974
8. Soloway JB, Cornett BM, Donahoo JV, et al: Differentiation of bleeding diatheses which occur following protamine correction of heparin anticoagulation. Am J Clin Pathol 60: 188–191, 1973
9. Schriver HG, Epstein SE, Mintz M: Statistical correlation and heparin sensitivity of activated partial thromboplastin time, whole blood coagulation time and an automated coagulation time. Am J Clin Pathol 60:323–329, 1973
10. Bowie EJW, Thompson JH Jr, Didisheim P, et al: Mayo Clinic Laboratory Manual of Hemostasis. Philadelphia, W.B. Saunders Co., 1971, 186 pp
11. Hattersley PG: Activated coagulation time of whole blood. JAMA 196:436–444, 1966
12. Bull BS, Huse WM, Brauer FS, et al: Heparin therapy during extracorporeal circulation. The use of a dose response curve to individualize heparin and protamine dosage. Thorac Cardiovasc Surg 69:685–689, 1975
13. Ellison N, Beatty CP, Blake DR, et al: Heparin rebound. J Thorac Cardiovasc Surg 67:723–729, 1974
14. Novak E, Sekhar NC, Dunham NW, et al: A comparative study of the effect of lung and gut heparins on platelet aggregation and protamine neutralization in man. Clin Med 79: 22–27, 1972
15. Jacques LB, Bell HJ: Determination of heparin. Methods Biochem Anal 7:253–309, 1959
16. Senn LY, Karlson KE: Methodologic and actual error of plasma volume determination. Surgery 44: 1095–1105, 1958
17. Altshuler JH, Altshuler TL, Halseth WL, et al: Hemotensiometry. A new technique for the study of hemostasis in open-heart surgery. FIEE Trans Biomed Engr BME-20:152–154, 1973

Malignant Hyperthermia

CURARE AND HYPERTHERMIA A number of investigators have claimed that it is probably safe to administer *d*-tubocurarine to a patient susceptible to malignant hyperthermia (MH). This report details the anesthetic management of two patients with a strong family history of MH. A 13-year-old Caucasian boy required surgery to correct bowel obstruction. Although he had no history of muscle abnormalities, 20 of his relatives had had non-rigid MH; eight had died in the perioperative period. The patient was premedicated with atropine and chlorpromazine; during a period of preoperative prophylactic cooling, he received meperidine, chlorpromazine, and promethazine. Rectal temperature was 36.1 C immediately prior to induction of anesthesia with nitrous oxide and oxygen, which was followed by intravenous injection of *d*-tubocurarine. Within five minutes after the administration of *d*-tubocurarine, rectal temperature was 39.7 C. The patient was treated by external cooling and no further *d*-tubocurarine was given. An uneventful recovery ensued. The second patient (with a strong family history of rigid MH) developed a rectal temperature of 40.6 C within 15 minutes after administration of *d*-tubocurarine. Neither patient manifested rigidity at any time. Serum CPK determinations performed several months after the two incidents were normal or minimally elevated. (*Britt BA, and others: Malignant hyperthermia induced by curare. Can Anaesth Soc J 21:37–375, 1974.*) ABSTRACTER'S COMMENT: What about the possibility that N_2O was the triggering agent?