

MAGUIRE, C. H., AND GRISWOLD, R. A.: *Further Observations on Penetrating Wounds of the Heart and Pericardium*. *Am. J. Surg.* 74: 721-731 (Nov.) 1947.

"In 1941 the above authors reported 47 cases of penetrating wounds of the heart and pericardium. . . . The group that we are presenting at the present includes an additional 33 cases admitted to the hospital with the diagnosis of a cardiac wound. . . . There is little or no premedication given as most of these patients are comatose and need no sedatives or narcotics. We have omitted narcotics from the pre-operative regimen because of the depressing effect on respiration. . . . There is little to be said about the choice of anesthesia as most of these patients need oxygen under positive pressure at the beginning of the operation and do not need an anesthetic agent until the tamponade has been released. After operation has been begun the anesthetist may begin to feed in a little nitrous oxide. We believe that cyclopropane should not be used because of the effect of the cyclopropane on the irritability of the heart. Positive pressure must be continued after opening of the pleural cavity and continued until the chest is closed.

"At this point, in regard to irritability of the heart, one small technical maneuver might be mentioned. Quite frequently during manipulation or rotation of the heart, during or after sutures are placed, the rhythm of the heart will become very irregular. This irregularity is very easily controlled by the use of 1 per cent novocaine sprayed over the surface of the heart. Within a space of seconds the irregular rhythm will become regular and further manipulation may be carried out."

8 references.

J. C. M. C.

MEMORANDUM FROM THE PUBLIC HEALTH LABORATORY SERVICE AND THE LONDON SECTOR PATHOLOGISTS' COMMITTEE: *Avoidable Meningitis*. *Lancet*: 2: 883-884 (Dec. 13) 1947.

"Every operative procedure entails some risk to the patient, but in simple operations like spinal puncture the risk ought to be practically negligible. The occurrence of meningitis following the withdrawal of cerebrospinal fluid or the administration of a spinal anaesthetic is a grave reflection on the methods used in many hospitals, because these 'accidents' can be avoided by the adoption of a simple and reliable technic. That such a technic is not in fact universally employed is attested by the number of cases of avoidable meningitis reported in the literature during the past few years. Furthermore, as Garrod (1946) points out, 'there is a natural reluctance to publish anything which may appear discreditable. . . . It is therefore probable that meningitis following spinal anaesthesia has been far commoner than the literature of the subject would suggest.' This statement is endorsed by surgeons and anaesthetists whenever the subject comes up for discussion. . . . The ideal would be to adopt the full aseptic ritual of a surgical operation for every spinal puncture. In many cases the time and place render this impossible. The following recommendations are therefore offered, not necessarily as ideal procedures but as practical methods applicable in nearly all circumstances. . . . If facilities are available, all apparatus including manometer should be enclosed within suitable containers and sterilised either by autoclaving at 15 to 20 lb. pressure for twenty minutes or by dry heat at 160 C. for an hour. . . .

"If autoclaving or dry-heat sterilisation cannot be employed, all apparatus should be sterilised immediately