Kerr, H. H.: Aortic Embolectomy. M. Ann. District of Columbia 4: 249, 1935.

The author describes the symptoms and findings in a case of operative removal of a saddle embolus of the aorta. As a result of this study he suggests that in cases of saddle embolus the femoral artery be exposed in Scarpa's Triangle under local anesthesia. A soft rubber tube, slightly smaller than the lumen of the vessel and attached to a suction apparatus, should then be passed into the vessel a centimeter at a time after thorough lubrication with sterile oil. After advancing the tube up the vessel 1 cm. it should be withdrawn and again advanced up the vessel an additional centimeter. In this way, advancing the suction a centimeter at a time, any clot in the vessel may be caught in the tube and withdrawn. Should the tube be forced directly up to the bifurcation there would be danger of forcing the embolus into the opposite iliac system.

Such a surgical attack upon a saddle embolus of the aorta would be a minor procedure compared with the extensive abdominal dissection that is necessary to expose the aorta and its bifurcation. In case of embolic block of the main vessels of the upper extremity in the axilla, or of the lower extremity at the femoral or popliteal area, the same procedure could be carried out.

H. McC.

Ettinger, G. Harold, and Hall, G. Edward: Synergy of Adrenaline and Acetylcholine on the Pulmonary Blood Vessels in the Rabbit. Quart. J. Exper. Physiol. 25: 18, 1935.

The tunica media of the pulmonary artery and arteriole of the rabbit is capable of causing death by firm contraction. It has an abundant nerve supply apparently capable of handling wide variations in the contractile state of the artery, but the feeble reactions of the pulmonary artery to adrenalin and sympathetic stimulation indicate that the sympathetic nerves would hardly control the necessary variations in caliber. The powerful vasoconstricting effect of acetylcholine coupled with results of vagus stimulation suggests that the vagus or other parasympathetic fibers may be responsible for the greater part of the vasoconstriction.

E. A.

Kirklin, O. L.: Obstruction of the Right Innominate and Left Subclavian Arteries With Orthostatic Syncope. Proc. Staff. Meet. Mayo Clinic 10: 673, 1935.

A man fifty years old complained of attacks of syncope preceded by blurring of vision. On several occasions he had experienced sensations of fainting without losing consciousness. All the episodes occurred when the patient was in the erect posture. The blood pressure could not be determined in the right arm; in the left arm it was 70 systolic and 60 diastolic when the patient was recumbent; it was somewhat lower when the patient sat and could not be determined when he stood. Pulsations were absent in the right carotid, subclavian, axillary, brachial, radial, and ulnar arteries. Pulsations were faint in the left subclavian, axillary, brachial, radial, and ulnar arteries when the patient lay and disappeared when he stood. The nature of the lesion occluding the right innominate and subclavian arteries could not be determined. The brain received its blood from the left carotid artery alone and digital occlusion of it caused syncope. Ephedrine sulphate was used therapeutically but sufficient time had not elapsed to determine its efficiency.

E. A.