

metabolism is low and the infants generally exhibit marked inability to maintain normal body temperatures. The resistance to infection is low and mortality rate high.

### Air Conditioning Requirements

The optimum air conditions for the growth and development of these infants were determined by extensive research<sup>18</sup> at the Infants Hospital, Boston, Mass., using four valid criteria, namely, stability of body temperature, gain in weight, incidence of digestive syndromes, and mortality. Individual temperature requirements varied widely (from 72 to 100 F) according to the constitutional state of the infants and body weights. The optimum relative humidity was about 65 per cent, and the air movement less than 20 fpm.

A single nursery conditioned to 77 F and 65 per cent relative humidity was found to fulfill satisfactorily the requirements of the majority of premature infants. Additional heat for weak (or debilitated) infants may be furnished in the cribs or by means of electric incubators placed inside the conditioned nursery, and the temperature adjusted according to individual requirements. In this way multiplicity of chambers and of air conditioning apparatus is obviated; the infants in the heated beds derive the benefit of breathing cool humid air, and the nurses and doctors need not expose themselves to extreme conditions.

**Importance of Humidity:** Although external heat is an important factor in the maintenance of normal body temperature, humidity appears to be of equal or greater importance. When the premature nurseries at the Infants Hospital were kept at relative humidity between 25 and 50 per cent for two weeks or longer, the body temperature became unstable, gain in weight diminished, the incidence of gastro-intestinal disturbances increased, and the mortality rose. On the other hand, continuous exposure to air conditions with 55 to 65 per cent relative humidity gave satisfactory results over a period of years. The initial physiologic loss of body weight (loss occurring within first four days of life) was found to vary inversely with the humidity. In the old nurseries with natural humidity it averaged 12.4 per cent of the birth weight; in the conditioned nurseries it was 8.9 per cent with 25 to 49 per cent relative humidity, and 6.0 per cent with 50 to 75 per cent relative humidity. The number of days required to regain the birth weight was correspondingly maximum in the old nursery and minimum in the conditioned nurseries under high humidity.

Maximum gains in body weight occurred in the conditioned nurseries under high humidity (55 to 65 per cent) in infants weighing less than 5 lb. The gains were less under low humidity (25 to 50 per cent) in the same nurseries, and in the old nurseries prior to the installation of air conditioning apparatus.

The incidence and severity of digestive syndromes, with diarrhea, persistent vomiting, diminishing gain or loss of body weight, and other

<sup>18</sup>The Premature Infant: A Study of the Effect of Atmospheric Conditions on Growth and on Development, by K. D. Blackfan, C. P. Yaglou and K. McKenzie (*American Journal Diseases of Children*, 46: 1176, 1933).

symptoms, were generally from two to three times as high under low than under high humidity.

Summarizing, the best chances for life in premature infants are created by maintaining a relative humidity of 65 per cent in the nursery and by providing a uniform environmental temperature just sufficiently high to keep the body temperature within normal limits. Medical and nursing care are, of course, factors of equal and sometimes of greater importance.

### Air Conditioning Equipment

Most of the installations now in use are of the central system type providing for filtration, for humidification and heating in cold weather, and for cooling and dehumidification in hot weather. A high ventilation rate, between 15 and 25 air changes, is desirable to remove odors and maintain uniformity of temperatures in extremes of weather. Recirculation is not used extensively in these wards owing to odors and the possibility of infection.

### Control of Air-Borne Infection

The protection of the premature and older infant against infection is of the utmost importance. It was found in one installation equipped with air conditioning, germicidal lights and mechanical barriers that air conditioning alone did not prevent the spread of respiratory cross-infections. Bactericidal ultra-violet light barriers and air conditioning or mechanical barriers and air conditioning were efficient<sup>19</sup>. A brief preliminary report on the effect of propylene glycol vapor in reducing acute respiratory infections in a children's ward, suggests that it may be effective<sup>20</sup>.

### FEVER THERAPY

Artificial production of fever in man is an imitation of nature's way of overcoming invading pathogenic organisms. The action may be direct and specific by destruction of the invading organism within the safe limit of human temperatures, or indirect in the case of heat resistant organisms, by general mobilization of the defensive mechanisms of the body, which retard or neutralize the activity of pathogenic bacteria and their toxins. A serious challenge to the theory on which fever therapy is based comes from the demonstration that hyperpyrexia causes a reduction in the titer of circulating antibodies in experimental animals<sup>21</sup>.

The limits of induced systemic fever are usually between 104 and 107 F (rectal), and the duration from 3 to 8 hours at a time. The total period of fever treatment varies with the type of the organism involved from a few hours to 50 or more.

The diseases which respond favorably to artificial fever therapy are gonorrhea and its complications (which include arthritis, pelvic infections

<sup>19</sup>Observations on the Control of Respiratory Contagion in the Cradle, by I. Rosenstern (*Aerobiology, American Association for the Advancement of Science, Symposium* 17:242, 1942).

<sup>20</sup>The Effect of Propylene Glycol Vapor on the Incidence of Respiratory Infections in a Convalescent Home for Children, by T. N. Harris and J. Stokes, Jr. (*American Journal of Medical Sciences* 204:430, 1942).

<sup>21</sup>The Influences of Artificial Fever on Mechanisms of Resistance, by H. V. Ellingson and P. F. Clark (*Journal of Immunology*, 43:65, 1942).