to be more effective than when either one of the two is used alone, but the proof for this has yet to come.

The present status (1947) is admirably reviewed by the Committee on Sanitary Engineering of the *National Research Council*[12], and by a subcommittee of the *American Public Health Association*[13]. Both committees feel that the problem of air disinfection is still in the experimental stage.

More experimentation is needed for arriving at a definite conclusion concerning its use in industry and public buildings.

VALUE OF AIR COOLING UNDER TROPICAL CONDITIONS

The commissioning of a class of naval hospital ships with all wards, laboratories and living spaces air cooled is a notable achievement to provide better treatment of patients, especially those suffering from extensive burns, by control of environmental factors. Although statistics are not at hand to indicate the deaths or retarded recoveries of patients due to lack of air cooling in ships operating in tropical waters, it is generally agreed among competent observers that high temperature and humidity are major factors in prolonging disability and increasing mortality of the sick and injured. Physiologic data obtained on healthy men, moreover, show the large loss of body fluids and the stress on the cardiovascular system in terms of increased pulse rate when these men are continuously subjected to high temperatures. Even at rest about 50 cc of fluid per hour are lost as sweat[14] through intact skin. In burn patients the difficulty, encountered in temperate climates, of maintaining fluid and electrolyte balance is tremendously augmented by the additional evaporative fluid loss in hot environments.

Frequently from 50 to 75 per cent of personnel aboard naval vessels operating in tropical waters are afflcted with heat rash to a degree that interferes with rest and sleep. In carefully controlled experiments[14] it was possible to produce a fulminating type of rash in all men living continuously at an effective temperature of 85 (90 F dry-bulb and 83 F wet-bulb). In the control group, 12 out of 24 hr were spent in a relatively cool atmosphere of 75 ET (80 F dry-bulb, and 70 F wet-bulb). These men either remained free from heat rash or occasionally developed a mild form. Thus, intermittent cooling to a degree which prevented sweating in men at rest eliminated a serious handicap to good performance of duty.

In both laboratory tests and aboard hospital ships a relatively cool living environment of 76 to 78 ET provided an atmosphere conducive to rest and sleep without excessive sweating. Berthing spaces tended to have extremely low odor levels. Motivation, initiative and alertness, in contrast to the usual irritability and lack of incentive incident to residence in tropical climate, were maintained[15].

Little has been done, however, to obtain practical methods for application of air conditioning under heavy heat loads and on the enormous scale that would be needed to modify life in the tropics. It is not improbable that cooled houses in a tropical climate, if used consistently for one generation, might modify the whole character of a population. The obvious advantages of part time cooling on personnel to promote rest and sleep in tropical areas would provide a prophylactic measure of great potential importance.

TREATMENT OF DISEASE

In the past few years considerable progress has been made in using air conditioning as an adjunct in the treatment of various diseases. Among the important applications are those in operating rooms, nurseries for premature infants, maternity and delivery rooms, children's wards, clinics for arthritic patients, heat therapy, cold therapy, oxygen therapy, X-ray rooms, the control of allergic disorders, and for the physiological effects in industry.

OPERATING ROOMS

The widest application of air conditioning in hospitals is in operating rooms. Complete air conditioning of operating wards is important because winter humidification helps reduce the danger of anesthetic gases; summer cooling with some dehumidification tends to eliminate excessive fatigue and to protect the patient and operating personnel; and finally, filtering aids the removal of allergens from the operating room air.

Reducing Explosion Hazard

Explosion hazards in operating rooms began with the introduction of modern anesthetic gases and apparatus. Ether administered by the old drop method gives rise to an explosive mixture, but in practice this method is still regarded as comparatively safe. When ether is mixed with pure oxygen, or nitrous oxide in certain concentrations, the explosion hazard may be as great as with ethylene-oxygen, or cyclopropane-oxygen mixtures.

Of the anesthetic gases nitrous oxide alone does not explode but supports combustion. Ether, vinyl ether, ethylene, and cyclopropane are as potentially dangerous as gasoline or illuminating gas in the home[16]. Chloroform does not explode violently in contact with flame but decomposes to liberate phosgene. All of the anesthetic gases and vapors except ethylene are heavier than air. Although the incidence of injury or death from explosion is negligible compared with other hazards in the operating room, the dramatic features surrounding an explosion justify continued investigation to eliminate the hazard.

During the course of ethylene anesthesia, the mixture, usually 80 per cent ethylene and 20 per cent oxygen, is so rich that the danger of explosion is slight in the immediate vicinity of the face mask, but leakage of ethylene into the air may accumulate to any lower concentration, and thus introduce a serious hazard. The most dangerous period is at the end of the operation when the patient's lungs and the anesthesia apparatus are customarily *washed out* with oxygen with or without the addition of carbon dioxide. Even when this procedure is omitted, it is difficult in practice to avoid dilution of the anesthetic gas with air during the normal course of breathing following the administration. In either case the mixture would pass through the explosion range and extraordinary precaution is necessary for the safety of the patient and operating personnel.

In a study[17] of 230 anesthetic explosions and fires, 70 per cent of the explosions and 60 per cent of the deaths were caused by igniting agents other then static sparks. In 1941 the *National Fire Protection Association*[18] made certain recommendations for safe practice based on available information. Some of these recommendations are:

Windows should be kept closed so that the air conditioning system can prevent pooling of explosive anesthetic gases. Twelve air changes per hour and a humidity of 55 per cent are advised. If a higher humidity were compatible with the well being of the patient and personnel, it should be maintained. All electrical installations should comply with the standards set by the *National Electrical Code* for use in explosive situations. Cautery