recirculated air is a recognized practice. It is certain that such a system must have the necessary precautions (regarding the electrical and air moving equipment) against the hazard of gross spillage of the anesthetics. Systems using 100 percent outdoor air and adequate air removal means are regarded as following the best practice. The choice between the systems is usually made on the basis of first costs. As compared with the other daily usage costs of an operating room, the differences between the operating costs of the various air conditioning systems is not a significant item.

Good thermal construction of the operating rooms is a recommended practice. Much can be gained by thermal insulation of sterilizing equipment, and by exhaust ventilation of sterilizing rooms adjoining the operating rooms. The amount of glass surface should be kept to a minimum, particularly in walls exposed to the sun. Double windows are desirable and often necessary to prevent condensation on the glass in cold weather. The equipment capacity and control methods must be properly selected for the type of system employed, and for the loads encountered. The resulting air flow rates are usually in the range of 8 to 12 changes per hour. The method of air introduction should be selected to keep air movement in the operating area under 50 fpm. Where all outdoor air or a large percentage of outdoor air is used, the air introduction and exhaust arrangements should be designed to provide a thorough air change in all parts of the room. This may be accomplished by introducing the air at one side and exhausting it from the other side of a small room or by introducing the air at the center and exhausting from the sides of a large room. The supply and exhaust arrangements can be exchanged in the case of large rooms. An air-conditioned recovery ward in connection with the air-conditioned operating room, is of great value in stabilizing peripheral circulation, and in reducing excessive loss of fluids on hot humid days.

NURSERIES FOR PREMATURE INFANTS

One of the most important requirements in the care of premature infants is the stabilization of body temperature. This is necessary because the infant's heat regulatory system is not fully developed, with the resultant tendency for environmental temperature to influence body temperature. The younger the premature infant, the greater is the tendency. As the infant's metabolism is low, heat production is not adequate to maintain a normal body temperature in a cool environment. The resistance to infection is low, and the mortality rate is high. In general, the younger the age of the premature infant, the higher the mortality rate.

Nurseries constructed for metabolic research should be air-conditioned so that conditions are reproducible. Results of such studies may be invalid if environmental conditions are not identical, since fluid and electrolyte loss may vary greatly with change in environmental conditions.

Air-Conditioning Requirements

The optimum air conditions for growth and development of premature infants were determined by extensive research[41] at the Children's 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 percent, and the air movement less than 20 fpm.

A single nursery conditioned to 77 F and 65 percent 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, with temperature adjusted according to individual requirements. In this way a 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 Children's Hospital were kept at relative humidity between 25 and 50 percent 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 percent 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 percent of the birth weight; in the conditioned nurseries it was 8.9 percent with 25 to 49 percent relative humidity, and 6.0 percent with 50 to 75 percent 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 percent) in infants weighing less than 5 lb. The gains were less under low humidity (25 to 50 percent) in the same nurseries, and in the old nurseries prior to use of air-conditioning apparatus.

The incidence and severity of digestive syndromes, with diarrhea, persistent vomiting, diminishing gain or loss of body weight, and other symptoms, were generally from two to three times as high under low as under high humidity.

Summarizing, the best chances for life in premature infants are created by maintaining a relative humidity of 65 percent 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

Many 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 ventilation rate between 8 and 12 air changes per hour is desirable to remove odors and maintain uniformity of temperatures in extremes of weather. Recirculation should not be used in these wards owing to odors and the possibility of infection. There should be a frequent change in spray water.

Control of Airborne 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 respiratory cross-infections.[42] Bacterial ultraviolet barriers, air conditioning and mechanical barriers are efficient. However, infections are brought in by, and often spread by, ward personnel in spite of these measures.

FEVER THERAPY

Artificial production of high fever in man can be considered 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.

Although the action may be direct and specific by destruction of the invading organisms within the safe human limits, fever therapy exerts much of its benefit through the improvement of the mechanism of bodily defense. A serious challenge to the theory on which fever therapy is based comes from the demonstration that high fever causes a reduction in the concentration of circulating antibodies in experimental animals.

Patients for fever therapy should be carefully selected. The most serious complications which may arise are heat stroke, heat exhaustion and circulatory collapse. The chief minor complications are heat cramps, fever blisters and mild dehydration.

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.

The diseases which respond favorably to artificial fever therapy are gonorrhea and its complications (which include arthritis, pelvic infections in women, and involvement of the eye), syphilis and chorea.

The most striking results are seen in gonorrhea and syphilis, since the causative organisms can be destroyed at temperatures compatible with human life. However, the use of fever therapy has decreased since penicillin has been found so effective in the treatment of gonorrhea and syphilis. Mild fever, up to 101 F for one hour, has revently been used in the treatment of rheumatoid arthritis. This degree of fever is not bactericidal, but is believed to stimulate the body defense mechanism.

Equipment for Production of Fever

Artificial fever can be induced by injections of various crystalloid or colloid substances, bacterial products of typhoid and malarial organisms, or by physical methods using hot baths, radiant heat cabinets, hot humidified air cabinets, or by short wave diathermy in combination with a cabinet.

The relative advantages of various methods have been evaluated clinically.[43] Among the devices for the production of fever by physical means, the one most widely used is the hot humid air or *air-conditioned* cabinet. This apparatus was developed at the Kettering Institute for Medical Research at Miami Valley Hospital in Dayton, Ohio.

In the earlier studies of the Society, temperatures were elevated more easily using saturated atmospheres. A fever therapy apparatus[44] using these same principles has proved efficient as a means of inducing and maintaining fever in a body, with small likelihood of burns because of the comparatively low dry-bulb temperatures.

When heat is necessary in treating legs or arms, such media as short- or long-wave diathermy, micro-waves, infrared, water baths, etc., have been used extensively. A recent development, a saturated atmosphere heating unit, similar to one previously described has proven satisfactory, because heat may be administered over longer periods which render deep heating possible without fear of burns or shocks. Local heating has been somewhat satisfactory in relieving the painful symptoms of peripheral vascular disease. This procedure, however, is not without danger. Elevation of tissue temperature increases cell metabolism and the need for oxygen. The inadequate blood supply and oxygen deficiency may lead to tissue death or gangrene. Application of heat to the trunk or abdomen, with consequent reflex dilatation of the vessels of the extremities, eliminates this danger of local heat application.

Short-wave diathermy within the cabinet during the induction phase has been used. When the desired body temperature has been reached by electrical induction, the atmosphere of the enclosure is kept at saturation to prevent heat loss, thus maintaining the patient's temperature at the desired point. The two underlying principles in the production of fever by the hot humid air cabinet are: (1) the transfer of heat by conduction from the circulating hot air to the body, and (2) prevention of heat loss. The latter is more important. In an atmosphere of high humidity, the heat loss by evaporation is markedly decreased.

COLD THERAPY

Cold as an anesthetic agent was advocated by Allen several years ago.[8] Freezing of the tissue must be avoided. For certain patients, in whom amputation of an extremity is indicated, the application of a tourniquet with cooling of the affected extremity down to near freezing (5 C or 40 F) is of value. The patient, following this procedure can be prepared for surgery without the handicap of absorption of septic products and severe pain. This procedure has proven especially valuable in the neglected diabetic patient with an infected gangrenous extremity. Time for treatment of coma and hydration of the patient is gained. However, if amputation of an extremity is not indicated, the application of a tourniquet and packing in ice are dangerous procedures, since loss of the limb usually results. An extremity with inadequate blood supply can be readily cooled without the use of a tourniquet, but such an extremity is also usually eventually lost. Cooling is said to reduce the metabolism of the tissue with suspension of the vital processes. It also reduces the blood flow to practically zero, and few extremities with inadequate blood supply remain viable or recover.

Packing in ice, or use of low temperatures, is contraindicated in the treatment of patients with frostbite, immersion foot or trench foot. The affected extremities should be exposed to the air in a cool room and not rubbed with snow or packed in ice. The lowering of temperature by packing the body in ice for treatment of cancer has not proven successful.

The methods used for refrigeration, depending upon available facilities, are as follows:[44]

(1) Cracked or shaved ice which is simple and has the advantage of not freezing tissues. However, it is cumbersome and sloppy to handle and is unsuited to prolonged treatments.

(2) Use of ice in a pail for immersion of local parts.

(3) Special boxes for holding ice with padded or curtained openings for the limb.

(4) Bare ice bags and cloth bags for iced wet dressings for prolonged treatments and convenience.