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 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 [14, 15, 16].

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 [17]. 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 is needed to eliminate excessive fatigue and to protect the patient and operating personnel; and finally, filtering for 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 [18].

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 [19]. 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 [20] 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* [21] 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 equipment should not be used in hazardous locations. To prevent static sparks, all bodies in an operating room should be conductive or coupled. It is essential that adequate grounding be provided for the floor and every object in the operating room. Conductive rubber should be used on shoes, leg tips, operating table coverings and all rubber parts of the anesthesia equipment. All furniture in contact with the floor should be metal. In the absence of complete grounding facilities, the simple method of intercoupling patient, operating table, anesthetist and gas machine at ground potential may be used.

Experience has shown that neither high humidity nor intercoupling devices have eliminated the danger from static electric discharge. The removal of gas concentrations from the operating table area by means of specially devised exhaust ventilation should be thoroughly tested. Portable duct systems as installed aboard ship should be acceptable. Serious explosions can occur in a closed system but proper precautions will reduce this hazard to a minimum.

It should be realized that when a room and the occupants have been completely grounded there is always the possibility that the patient or the operator might receive a dangerous shock if a short circuit developed in any of the electrical equipment.

A comprehensive study of the explosion problem and of the general causes and prevention of operating room hazards by the *University of Pittsburgh*, the A.S.H.V.E. Research Laboratory, and the *U. S. Bureau of Mines* has led to a fruitful attempt to eliminate the explosive range of cyclopropane, one of the best but most difficult gases to handle. The use of helium as a diluent in the total gaseous mixture controls the oxygen concentration by replacement and, because of its flame quenching properties, it is the ideal gas for this purpose. In addition, a gaseous mixture containing helium is more difficult to ignite by electric discharges and this quality also increases the safety factor of anesthetic administration.