

The types of oxygen therapy in use at the hospital are: "(1) Oropharyngeal insufflation; (2) Open box (or open top tent); (3) Closed box (or closed top tent); (4) Masks; (5) Positive pressure methods by (a) mask and (b) machine; (6) carbon dioxide absorber methods by (a) mask and (b) machine."

The authors devised a simple closed box technic using a pliofilm and covering the top with pliofilm, and placing a container of exposed soda lime inside the tent. The authors prefer the O.E.M. to the B.L.B. masks. Oxygen was also administered to patients where positive pressure was desired, using an anesthesia machine. They used the anesthesia machine with administration of helium-oxygen, using carbon dioxide absorption.

In the opinion of the authors the oropharyngeal method of administering oxygen is the best in the hands of the untrained personnel where oxygen tents are employed. It is important to have a trained personnel who are constantly checking the apparatus as well as doing frequent gas analysis when other methods are used. They feel that the use of masks can only be of value where oxygen is needed for a short period of time since most patients get uncomfortable with the mask in proper position over several hours.

The authors have set up a good record system for inhalation therapy. They start with a form signed by the physician requesting the type of oxygen he wishes to be given the patient. The nurse technician keeps a daily record on the cases given oxygen she has supervised throughout the day and this sheet is sent to the bookkeeper's office for billing purposes. Then a record of therapy is kept on the patient's charts which notes the "type of therapy, the time instituted, oxygen percentage, the course of the therapy, and

many other remarks which may be of importance." "This form acquaints the physician in charge with the efficiency of the treatment during his absence from the bedside and serves as a basis for any alteration in the method used." The Hollerith method of analyzing statistical data with code numbers and punch cards is used to analyze these records.

In conclusion the success or failure of oxygen therapy depends primarily on "day by day conscientious supervision of the apparatus when actually in use."

M. L. B.

LAMBERTSEN, CHRISTIAN J., AND GODFREY, LINCOLN: *A Small Efficient Hood for Oxygen Therapy*. J. A. M. A. 125: 492-493 (June 17) 1944.

The authors have devised a small helmet or hood which is used in place of the large canopy and is attached by the usual means to the oxygen tent cabinet. This small hood or helmet was devised in an attempt to minimize the psychic objection of claustrophobia and feeling of suffocation that some patients have in a large tent. "This oxygen therapy unit comprises a small, completely transparent hood enclosing the head and neck, designed to be removably attached by outlet and inlet tubes to the air conditioning machine of the standard oxygen tent and to be snugly sealed about the neck of the patient by means of an attached skirt" (pliofilm skirt). The hood is made of a colorless plastic and is the shape of an egg shell bisected longitudinally. Soda lime is used in the air conditioning machine since one is dealing with a smaller circulatory air space. The hood's only contact with the patient is at the lower point where it rests on the patient's chest.

The author does not state what air conditioning machine of the standard oxygen tent type they used; however,

almost any standard type unit can be used. Some of the advantages of this hood over the large oxygen tent are accessibility of the patient to the many nursing procedures that are necessary in an acutely ill patient, such as, intravenous medication, electrocardiograms, bed bath. The authors state that the visibility through this hood is good, and that some patients have been able to read without eye strain. Patients with a great deal of expectoration or who are vomiting are not handled well in this type of hood. If the motor stops and the patient is left in the hood they will accumulate carbon dioxide which could be of a serious consequence in the unconscious patient.

They were able to maintain an average oxygen concentration of 50 per cent with an oxygen flow of 4 liters per minute, a concentration of 60 per cent with 6 liters, 75 per cent with 8 liters and 80 per cent with 10 liters per minute.

In a recent communication with the author I was informed that these plastic hoods were not on the market as yet.

M. L. B.

AAGESEN, WALTER J.: *Bilateral Eighth Nerve Paralysis Following Appendectomy Under Avertin Gas-Oxygen-Ether Anesthesia. Report of a Case.* Ann. Otol., Rhinol. & Laryngol. 53: 339 (June) 1944.

"This is a case report of a twelve-year-old girl who developed a bilateral eighth nerve paralysis following an appendectomy in which avertin and nitrous oxide-oxygen-ether were used as the anesthetic. A recent search of the literature has failed to disclose a case of similar nature. No specific cause is offered for this neurological accident. Correspondence from the manufacturers of avertin states that they can find no published descriptions of a similar accident in which

avertin was used as the basal anesthetic agent. . . .

"It is . . . well known that cerebral complications following surgical procedures in which nitrous oxide-oxygen-ether was used may result in cerebral anoxia and be followed by cerebral complications. A few of the reported complications are amaurosis, difficult speech, residual athetosis, emotional imbalance, hemiparesis, aphasia and apraxia. . . .

"As the case came under observation five months following the operative procedure, only the history and findings as described on the initial clinical record and those elicited from the mother, along with the findings at the present time, are offered. . . .

"This twelve-year-old, Irish-American girl weighed 35.5 Kg. at the time of her hospital admission. According to the mother, she developed rather sudden pain in her abdomen on May 10, 1943, while the mother was at work. On the mother's return a pediatrician was called and a diagnosis of acute appendicitis was made. The child was sent to the hospital. There was no history of nausea, vomiting, constipation or diarrhea. The child had a temperature of 100° F. and had a white blood count of 12,000 on admission; no differential count was made. The surgeon noted that the abdomen was spastic.

"Operation was deferred until the following morning, at which time the white blood count had risen to 19,000. At preoperative medication the child was given seconal gr. .75 at 5:30 A.M., and at 7:15 A.M. she was given morphine sulfate gr.  $\frac{1}{12}$  and hyoscine hydrobromide gr.  $\frac{1}{300}$ . At 7:50 A.M. she was given a 30 mg. per kilo basal dose of avertin over a twenty-minute period. Operation was begun at 8:15 A.M. and finished at 8:40 A.M.

"The following notes are taken from the anesthetic record: no excitement;