the acrylic. Since the bore of the glass tubing obtained from a dental carpule is about the same as that of a number 5 tracheostomy inner tube, the glass may be left in place. After polishing, the adapter is ready for use.

The clinical use of the adapter was found to be quite satisfactory by those of us who worked in the 39th Evacuation Hospital in the European Theater of Operations.

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CORRESPONDENCE

To the Editor:

A reprint (by Mallinckrodt) of the article "Anesthesia for the Patient in Shock" by R. B. Gould in *Anesthesiology*, 5: 129 (Mar.) 1944 brought to my attention this statement:

"Postoperative pulmonary complications, which many physicians attribute to irritation of the alveolar mucosa by ether, may occur if the vapor administered to the patient is saturated with ether at a temperature much higher than that of the body, when cooling of the vapor in the lungs might cause condensation of ether in liquid drops."

The first point I wish to bring up in the above statement is that it is impossible to deliver ether to the face piece of any machine at a higher temperature than the room temperature (about 20 C.) because of the low specific heat* of ether vapor (.0016 cals.); the usual 10 per cent ether vapor has a specific heat of only 0.004 cals. In other words we know that the temperature of ether is easily raised and conversely it is easily lost. It is just impossible to deliver it above room temperature.

The second point I wish to bring out is that the boiling point of ether is about 35 C. and the temperature in the alveoli is 37 C., so that even if you could accomplish the first point how much more impossible would be the latter.

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* The specific heat of a substance is the number of calories required to raise the temperature of 1 Gm. of that substance by 1 C.

To the Editor:

In this country adjustable metal armboards are not provided for operating room tables either for intravenous anesthesia or supportive therapy. An improvised ordinary wooden armboard, inserted under the mattress of the table and kept in place by the patient's own weight, will be satisfactory in quite a number of general surgical cases. I have been embarrassed several times, however, while using the continuous drip method of natrium pentothal combined with curare, particularly in gynecologic cases when steep Trendelenburg position has been employed. In such cases the armboard instead of being placed horizontally (flat) is turned sideways to an angle approximately 75° which makes the arm hang down without support being fixed only by bandage. After a considerable time the arm becomes blue due to venostasis. Apart from this there is constant danger of the needle slipping out or even of the arm being knocked by the surgeon's leg.

The brief report by Dr. Searles and Dr. Guest which appeared in Volume 8 of ANESTHESIOLOGY (Sept.) 1947, does not give the solution in cases of steep Trendelenburg.

The Adams-Rogers arm or leg board described in Lundy's Clinical Anesthesia and in Adams' Intravenous Anesthesia is adjustable mostly for either abduction or adduction of the board with the fixed arm, but it hardly provides a satisfactory solution for rotating the board about its own axis.