isms. Penicillin and streptomycin therapy was begun immediately.

At 4 o'clock the day following the block (24 hours later), the patient was feeling much better. He still had some headache, but it was milder than it had been at the onset of his illness. Therapy for his meningitis was continued.

On the second day following the block and 36 hours after the onset of his symptoms, a spinal-fluid examination showed a normal sugar and protein content, with 1,200 cells (60 per cent polymorphonuclears). Two days later, the patient no longer had any headache and there was no residual neck stiffness. He apparently was in good condition and was transferred back to the Orthopedic Service. A spinal-fluid examination made the day that the patient was transferred back to the Orthopedic Service showed 52 cells with 50 per cent lymphocytes and 2 polymorphonuclear cells. Cultures taken from the spinal-fluid specimens during the course of his illness showed no growth. Final impression of the Officer in Charge of the Isolation Section was that of meningitis secondary to chemical irritation.

The patient was seen again by the anesthesiologist when he returned to the Orthopedic Service. He was entirely free of symptoms or sequelae relative to his episode of meningitis. The complaints referable to his left leg, that is, swelling and pain no longer were experienced by the patient. He continued symptom-free from the time of his epidural block and was discharged.

In retrospect, cultures of the 2 per cent xylcocaine solution and normal saline solution which had been used were both reported negative by the laboratory upon culture. The spinal set used as the block set was one which had been run in the usual manner with dial control for sterilization. There was no deviation from standard procedure or any indication that sterile technique had been broken. Therefore this case must be accepted as an aseptic meningitis, probably due to chemical irritation from the solution used, with the portal of entry into the subarachnoid space undetermined.

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A SPECIAL PAD FOR PATIENTS IN THE PRONE POSITION

One of the problems of the anesthesiologist is that of maintaining adequate respiratory exchange in patients operated on in the prone position, as in orthopedic and neurosurgical procedures. The use of sandbags at the shoulders and the hips, rolled blankets, and specially built well-padded metal supports have all been employed, but all have disadvantages. With sandbags, the abdomen of an obese or a flexible patient may often be in contact with the operating table; the resultant increase in intra-abdominal pressure will impede the downward movement of the diaphragm in respiration, and increase in venous pressure and wound oozing may result from pressure on the inferior vena cava. Rolled blankets are difficult to maintain in the right position without collapsing. The metal support provides excellent operating conditions, but the center is high above the operating table and some difficulty is found in placing an unconscious patient upon the support.

By the use of specially shaped firm but compressible foam rubber pads, many of these difficulties have been relieved. Figure 1 indicates the shape and a description of the dimensions follows.

The dimensions are: a uniform thickness of 5 inches, width of each of the paired pads 6 inches at each end, narrowing to 3 inches in the middle, and a total length of 18 inches. The thickness has been found adequate even in the obese patient to relieve pressure on the abdomen when in proper position and the kidney shape allows lateral abdominal expansion as well. The ends of the pads which lie under the shoulders are attached by straps with buckles, and thus can be spread to vary with the width of
the patient so that the shoulders are supported without undue pressure on the thoracic cage. Fixed straps separate the pelvic end of the support by 3 inches to decrease pressure on the pubis and the femoral vessels. Pooling of blood in the legs may occur if care is not taken at the time of placing the patient in position. The proper position at the pelvic end depends on the anterior-superior iliac spine resting 1 inch above the lower edge of the pad, and not below or above, so that the pelvis is rotated around its horizontal axis in order to decrease the normal lumbar lordosis, thus allowing better surgical exposure to the vertebral laminae.

These pads* have been in use about a year, and have been found to be very satisfactory both for adequate operating conditions and freedom of respiratory movement.

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* V. Mueller & Co., Surgical Instruments, Chicago.

A SIMPLE CONSTANT MONITOR SYSTEM

Described below is a system which enables the anesthesiologist constantly and comfortably to monitor the vital fluctuations of blood pressure, pulse, and respirations. It consists of two components: (1) a monaural plastic ear mold and (2) tubing and connectors to attach the system to the conventional blood-pressure cuff stethoscope and to a chest piece over the precordium. Its total cost is between $15.00 and $20.00, varying with locality and components. Figure 1 is self-explanatory.

The ear mold is made for either ear, obtainable at any hearing-aid distributor's,* and is known as the "invisible" type. The tubing is of extruded vinyl or Tygon plastic, the standard plastic in-

* Available in the Los Angeles Area from the Ralph Burdieck Laboratories, 803 E. Broadway, Glendale 5, California.