of this complication varies and it is not intended to discuss that phase here.

As a prophylactic measure against the occurrence of brachial plexus paralysis resulting from the lateral decubitus, a special mattress has been used. The mattress used in continuous spinal anesthesia given according to the method of Lenum has been adapted. As illustrated, the mattress is constructed in two pieces (fig. 1). In the adapted form, the segment usually placed cephalad when the mattress is utilized in the continuous spinal technic is reversed upon itself. This causes the cut-out portion then to be in a suitable position for the patient's shoulder. A further modification is the separation of the small upper portion completely and its utilization solely as a head piece (fig. 2). The under-shoulder then fits into the area between these two segments (fig. 3). The distribution of the patient's weight is upon the lower half of the chest and the head (fig. 4), instead of being directly upon the underlying shoulder as occurs with the usual type of mattress. Suitable padding is placed beneath the arm, so that it does not rest directly upon the metal table. The mattress provides sufficient padding to keep the under-shoulder from the table top. Placing the weight of the patient partially upon his chest does not materially affect respiratory movements.

The mattress has been so used in approximately 100 cases, with seemingly good results.

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HOME-MADE ANESTHESIA SCREENS

The frail frame of the conventional type of single wire anesthesia screen has proved to be unsatisfactory for many operative procedures and has prompted the development of the types to be described. These screens have been used in this hospital for the past two years and have been eminently successful from the standpoint of the surgeon and the anesthesiologist. The surgeon is provided with a maximum of working
space and a minimum of interference in the performance of the operative procedure, and the anesthesiologist has ready access to the patient and adequate room to perform any desired manipulation.

These screens can be constructed with relative ease from readily available materials, they are inexpensive, and they can be used on all standard types of operating room tables. The base of the screen is 16-gauge sheet metal and the individual connecting strips, which are welded in place, are metal bars \( \frac{1}{8} \)-inch thick and \( \frac{1}{2} \)-inch wide; light tubular metal may also be used.

The screen shown in figure 1 was developed primarily for thyroid surgery and other cervical operations, practically all of which are performed under endotracheal anesthesia in this hospital. With the use of this screen, the endotracheal tube is readily accessible without interfering with the progress of the operative procedure, and the surgeon and his assistant have a wider range of unimpeded movement than is possible with the conventional type of screen. Similar benefit occurs when a mask rather than an endotracheal tube is employed.

For intrathoracic surgery and for those operations in which the patient is placed in a lateral position, we employ the screen demonstrated in figure 2. Here again, adequate working space is available for the surgeon and the anesthesiologist. In the...
Fig. 2A.

Fig. 2B.
procedures in which the surgeon desires the patient's arm to be elevated, the top of the screen provides a broad surface for support and protection of the extremity, which is padded with sheets where it is in contact with the metal. Depending on the girth of the patient, we employ one of three screens of this pattern which vary in height from 14 inches to 16½ inches to 18½ inches.
Because so many of our patients leave the operating room with blood or fluids running, the fluid carrier shown in figure 3 was improvised for use on the carts on which the patients are transported to the ward. The essential requirements for this stand are that it must be sturdy and stable, when placed under the mattress on the cart and sufficiently high just to clear through all doors.

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