nursing chart. We intend to continue to use this recovery record when our new building with a recovery room is completed. It also eliminates the problem of recording the care given to emergency cases operated on in the evenings, holidays, or weekends, when the recovery rooms in smaller hospitals are not functioning.

In the belief that other anesthetists in small hospitals may have a desire to change their anesthesia forms, I believe it may be of general interest to have this form publicized. It was printed locally, and I would be happy to hear what other men think of it.

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CARBON DIOXIDE ABSORBERS

To the Editor.—I shall be grateful if you will allow me to reply to your correspondent Dr. H. P. L. Ozorio. (ANESTHESIOLOGY 18: 793, 1957).

Dr. Ozorio states that Waters' canister "remained faithful all these years." Surely he does not really mean this. Waters' canister is merely a container and so constructed as to make no provision for the prevention of canalization and dead space. These serious disadvantages are often responsible for many of the weird and dangerous phenomena which make their intrusion into general anesthesia. As a matter of fact, your correspondent admits using canisters in which provision is made for ensuring compactness of the granules by mechanical compression. However, I feel that Professor Pask's idea of using a scourer is not technically sound, since in compressing the granules the apertures in the scourer tend to become obliterated; thus the presence of a scourer in the canister will act as a hindrance to the expired gases. This is obviously undesirable; also, the partially blocked scourer cannot disperse the gases uniformly.

May I again stress the virtues of the improved carbon dioxide absorber (ANESTHESIOLOGY 18: 339, 1957): (1) The granules are compressed evenly but minimally by means of a spring on a movable stainless steel filter, thus avoiding uneven dispersal of the gases. (2) The elimination of dead space. (3) The extreme ease with which the canister can be filled. (4) Different size canisters can be used with the same screw-in heads for varying respiratory requirements.

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MOUTH-TO-MOUTH RESPIRATION

To the Editor.—A description of Dr. Peter Safar's technique of mouth-to-mouth respiration was published in ANESTHESIOLOGY 18: 904, 1957.

I wish to state that the same technique and device were reported by J. Graziano and myself (Respiración Boca a Boca, V° Congreso Argentino de Anestesiología, pp. 43–46, October 1955, Ed. Nocito y Raño, Buenos Aires) in Buenos Aires at the Fifth Congress of Anesthesiology, October 1955. Just to estimate the value of the method we did oximeter measurements in some apnoeic patients during mouth-to-mouth respiration with our airway, and the readings were always below normal (75 to 91 per cent) after the first one to three minutes. We did not check alveolar carbon dioxide, but most probably it must be also hard to get low or normal levels.

ACTUAL OXIMETER READINGS: *Case 1*—34 years, orthopedic operation, thiopental-ether-oxygen-Flaxedil. Oximeter: before apnoea, 94 to 96 per cent; during apnoea (1 minute), 70 to 80 per cent; during mouth-to-mouth respiration with special airway, 83, 86, 90, 86, 88, 84, 80 per cent; and oxygen with gas machine, 88, 90, 95, 98 per cent. *Case 2*—50 years, abdominal operation, thiopental-ether-oxygen-Flaxedil. Oximeter: during apnoea (30 seconds), 75 per cent; during mouth-to-mouth respiration (3 minutes), 80, 85, 83, 86, 87, 86, 84 per cent; oxygen with gas machine, 86, 90, 93, 95, 94 per cent. *Case 3*—electroshock therapy, succinylcholine (175 mg.), apnoea 5 minutes. Oximeter: before apnoea, 98 per cent; during apnoea, 83 to 77 per cent; during mouth-to-mouth respiration (1 minute), 90, 86, 91, 88, 80, 81, 88, 85