and water, and then proceed to carefully shave the area to be prepared, using a good lather of soap, and being very careful not to scratch the skin; at the same time direct your assistant to empty your basin and place fresh water ready for you to wash again. Having wiped off the shaving soap, you next take a nail brush (that has been boiled and kept in some antiseptic lotion), and you give a thorough cleansing to the part with hot soap and water—where the fluid ether soap can be obtained it is very nice for this stage—next take some clean absorbent wool or lint, and thoroughly rub all over the surface with either ether or benzine to remove the skin's natural greasy protection. Then again thoroughly wash your own hands, and soak them in hyd. perchlor. for some minutes; from this stage onwards you must be most particular that you touch nothing which is not properly sterilised, and you must either have an assistant to hand the things to you, or else you must have everything quite ready to hand, and all boxes open, etc. If you are going to put on a carbolic compress you will now take some sterilised lint, and for some minutes will wash the part with 1 in 40 carbolic lotion, and then apply a compress of lint, which has been boiled for half-an-hour, and has then been, for some time, soaking in 1 in 40 carbolic lotion; if you are going to apply a compress of hyd. perchlor. you would wash with hyd. perchlor., 1 in 2,000 (instead of with the carbolic lotion), and then apply the compress, which would have been boiled, and soaking in hyd. perchlor., 1 in 2,000, in exactly the same way. The compress should be well covered with jaconette or Bilroth's cambric (I prefer the latter, as it is softer, and can be boiled repeatedly), then sufficient wool to enable you to bandage it on firmly and comfortably. You must always examine your compress on the morning of the operation, and if it has slipped off at all, or become soiled in any way, reapply it with all the same aseptic precautions as before. Some surgeons like the compresses to be changed on the morning of the operation whether they have become disarranged or not. Never disregard a patient's complaint that a compress is burning him; some skins are much more sensitive than others, and it would be much wiser to replace the compress by another one that had been soaking in a weaker solution of the antiseptic, than to risk the surface of the skin being burnt, as the operation would then have to be postponed.

Try to realise the fact that the skin is always a happy hunting ground for microbes, and unless you are *very* thorough in your proceedings against them, they only wait for the surgeon to make his incision for them to creep inside the wound, and then your hope of its healing up by first intention vanishes away, and the patient is condemned to weeks of bed with a suppurating wound, the nurse to a daily dressing, and the hospital to the expense of maintaining the patient, and the cost of the dressing for a much extended period.

In large hospitals the dressers generally put on the compresses, but where this important work is entrusted to the nurses, you must try to show that you are worthy of the trust by being most thorough in your surgical cleanliness. The room should be nice and warm when you are going to put on a compress, so that you need not hurry for fear of the patient becoming chilled, and, of course, you would never attempt to put on a compress after attending to a septic case. With regard to the preparation of a patient for an anæsthetic, it is usual to give an aperient (castor oil, if possible) the afternoon before, and if it does not act freely, to give a soap enema on the morning of the operation; where the operation is an abdominal one the soap enema should be given in any case. Some surgeons prefer for their abdominal sections to have the aperient two nights before, and then an enema the night before, and another on the morning of the operation; this appears to answer very well, and it also insures a quieter night for the patient immediately before the operation. For operations on the rectum an enema of warm boracic lotion should also be given two hours before the operation. For operations in the region of the vagina or the uterus, a vaginal douche should be given about half-an-hour before the operation, and the catheter passed immediately before the patient is taken down to the theatre.

Any vomiting when under the anæsthetic is so extremely dangerous (as the vomit may be drawn back into the trachea and choke the patient) that we always try to prevent it by keeping the patient without any food for five or six hours before the operation; very feeble and exhausted patients or little children may not be able to stand such a long fast, but, in any case, no solid food must be given. If by any chance the patient should obtain food shortly before an operation the fact *must* be reported to the surgeon, and he may have to postpone the operation. Great care must be taken that the patient is warmly wrapped up before an operation; a loose flannel gown open all down the back is the most suitable garment, as there must be nothing tight around the patient to impede his respiration. Little children or very weakly patients should have their legs and arms wrapped up in warm gamgee tissue loosely bandaged.

R. C.

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