About two hours after the operation the patient is usually placed in the oblique position with his shoulders well raised by pillows or some mechanical contrivance. In this position he is much more comfortable and breathes more easily; pulmonary complications are less likely, and after gastro-enterostomy the contents of the stomach drain away more freely into the intestine. After operations for appendicitis with suppuration the sitting-up or Fowler position tends to limit the infection to the pelvis; it also facilitates drainage soon after operations for general peritonitis. For some operations upon the biliary apparatus it is, however, an advantage for the patient to keep nearly flat for about twelve hours until limiting adhesions have formed to prevent leakage of bile into the peritoneal cavity.

From the first the patient is encouraged to move his feet and legs in order to prevent wasting. In some cases massage of the limbs is very useful for the same reason. Free use of the limbs and a change of position by the nurse at first and later by the patient also tend to prevent thrombosis with pulmonary embolism. Change of position and active movements are valuable also in preventing pulmonary complications. For the same reason it is not good for the patient to be kept in bed too long. In most cases the patient can be lifted on to a couch at the end of four or five days and begin to walk at the end of a week or ten days. I believe that stagnation in bed is one common cause of thrombosis, pulmonary embolism, and pulmonary complications generally. After many operations the patient can safely leave the hospital or nursing home for a convalescent home at the end of a fortnight, but it is rarely wise for him to return to work under three or four weeks from the date of the operation. A too early return leads to an incomplete recovery of general health.

(2) **Shock.** To lessen shock the head is depressed, the abdomen is firmly supported by a many-tailed bandage, and sometimes by a large towel in addition, and the patient is kept warm with blankets and hot-water bottles. In many cases an infusion of about one pint of warm normal saline solution (temp. 105° F.) or an isotonic solution of dextrose is given into the middle of each axilla immediately after the patient is returned to bed; and an ampoule of pituitary extract is injected either intramuscularly or directly into a vein. In a few cases of great urgency, when the circulation is too poor to absorb the saline solution from the armpit, it is given directly into a vein, usually the median basilic. No more than three pints are to be given at a time for fear of causing œdema of the lungs. It is better to repeat the injection after two hours if necessary. In most cases it is sufficient to give a saline enema of one pint containing 20 to 30 grains of aspirin very slowly. The aspirin eases pain. Half a pint of saline is administered by the rectum every three or four hours until vomiting has ceased and

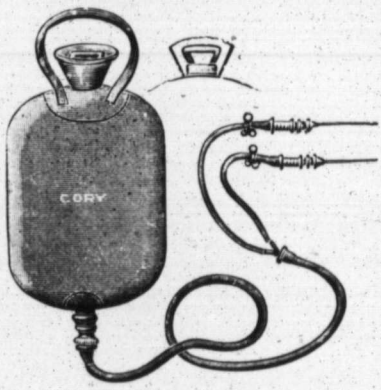

FIG. 11. *Infusion Apparatus.* The whole can be boiled and is very convenient to carry. The rubber bag holds three pints. The rubber tube is long and the needles of good size. They are generally passed through the pectoralis major into the middle of the axilla. A flannel cover for the bag is useful to keep the solution warm.