extensive local hemorrhage will not obstruct visibility such that the bleeding point cannot be
located.

Having observed fifty consecutive patients operated upon in this position, it is our im-
pression that the postoperative course is greatly improved. Possibly this reduced reaction is
due to the fact that blood does not gravitate into and fill the basal cisterns and subarachnoid
space as it must do in the conventional position.

During operation in this position an excessive amount of mucus drains out of the mouth
along the intratraeheal tube. How much of this passes into the tracheobronchial tree when
the patient is lying on his back cannot be determined, but it seems logical that it is better
to have it gravitate out along the tube than to rely solely on the use of suction to remove this
accumulated secretion.

This position is particularly well suited to the treatment of subdural hematomas and
brain abscesses. The drapes can be so arranged that the operative field includes both frontal,
temporal and parietal areas. Bilateral exploration can be done without altering the position
or redraping the patient's head. Furthermore, drainage of both hematomas and abscesses is
aided by gravity.

It is hoped that the use of this position will improve the surgical exposure of the optic
chiasm and circle of Willis, as well as aid in the repair of skull defects and exploration of lesions
of the orbit and frontal lobe.*

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PERIPHERAL NERVE LESION CHARTS

Curt P. Richter, Ph.D., and P. D. Malone, B.S.

Psychobiological Laboratory, Phipps Psychiatric Clinic, The Johns
Hopkins Hospital, Baltimore, Maryland

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For the examination and study of peripheral nerve lesions it is important to have simple
and accurate outlines of the areas of anaesthesia, high skin resistance, etc. The body charts
that have been available for this purpose have a number of serious shortcomings. In the first
place they usually show only the front and rear views of the extremities, leaving large blind
areas along the lateral and inner surfaces. Second, the positions of the arms and hands are
often unnatural and uncomfortable and almost impossible for men with peripheral nerve
lesions to hold at all. Third, they do not show any landmarks, without which it is very difficult
to transfer the outlines of the affected areas to the chart with any degree of accuracy.

During the past two years, while making skin resistance studies on patients with peripheral
nerve lesions at the Walter Reed General and Johns Hopkins Hospitals, we experimented
with a number of charts. A series of charts were finally designed which do not have the afore-
mentioned shortcomings.

Fig. 1 shows the chart for the right upper extremity. The central drawings give the front
and rear views of the forearm with the forearm flexed at right angles. Most patients with
peripheral nerve injuries can easily hold their arm in this position even though they are unable
to let their forearms hang freely at the side of the body. This position does not show the pos-
terior and anterior surfaces of the arm, the ulnar and radial surfaces of the forearm, nor the
lateral and medial surfaces of the fingers. All of these areas are shown in the drawings at the
two sides of the chart in which the forearm hangs freely at the side of the body with the

* The head rest will be available through the American Sterilizer Company, Erie, Pennsylvania.
palmar surface turned toward the body. This is a natural hanging position of the forearm. The drawing at the top and center of the chart shows the axilla and the surrounding region. Thus these charts show every part of the skin on the upper extremity, that is, they do not have any so-called blind areas. The black circles placed over bony prominences aid in copying the pattern of the affected areas. A reverse chart is used for the left upper extremity.

Fig. 2 shows the chart for the lower extremities. The three views at the left give the front, rear and side views of both lower extremities. The half-squatting view at the right shows the inner surfaces of the legs and thighs and the pubic area. At the bottom the center drawings show the plantar surfaces of the feet; the drawings at the sides show enlarged views of the plantar and dorsal surfaces of the toes. These charts do not have any blind areas.

The charts should be printed in a light red, orange or green rather than in black, since peripheral nerve and other patterns drawn on the charts in pencil, ink or crayon show up much more clearly on charts printed with the colored inks. The orange or red colored charts have the advantage that in photographing they reproduce black.*

These charts can be used not only in mapping areas of anaesthesia and high electrical skin resistance produced by peripheral nerve lesions, but also areas of high electrical skin resistance produced by sympathectomy, spinal cord lesions, paravertebral nerve blocks and areas of anaesthesia produced by intervertebral discs; also for outlining skin grafts or other skin disturbances.

* These charts are printed by The Maryland Press, 402 Fallsway, Baltimore, Maryland.