

almost to the bottom of the bottle is substituted. Several vents are cut with scissors in the sides of this tube. The ether bottle is then filled almost to the top with chipped ice and screwed into place. By opening the valve on top to the "Full On" position, all the expired gas passes around and up through the ice. This method we found produced excellent cooling in the system. As the ice melts it will be found that the water in the bottom of the bottle will need to be emptied about every half-hour to prevent the building up of positive

pressure as the vents in the rubber tube become submerged.

One of our patients undergoing a spinal fusion had shown an increase in respiratory rate up to forty per minute. Within three minutes after the introduction of ice into the circuit, his respiratory rate fell to 18 per minute with a corresponding fall in pulse rate and blood pressure.

Yours truly,

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#### To the Editor:

For removal of growths of the kidney, I prefer spinal anaesthesia, whenever possible if no contraindication exists for it. However, the spinal anaesthesia should not be of the unilateral type, because although the whole tumour may be on one side, during its removal the surgeon often encroaches beyond the middle line as he sweeps his hand all around and tries to separate adhesions, particularly if the growth is a large one and its removal difficult due to dense adhesions. This encroachment beyond the middle line, the pull of the large sized retractors which often stretch beyond the middle line, the weight of the assistant's hand on the other side, the tight packing necessary where pus is suspected, and the difficult act of bringing up the tumour on the surface of the wound—all contribute to the production of pain and severe surgical shock if the spinal anaesthesia is strictly unilateral and the patient conscious.

I have witnessed a case in which severe shock occurred leading to death under such conditions, i.e., in a strictly unilateral spinal in a conscious patient. The shock was due to the fact that the patient, a weak man, was unable to bear pain as soon as the operator's hand and fingers went beyond the middle line and above the upper limit of spinal anaesthesia. The anaesthetist had underjudged the upper limit of the

growth which went up as far as the diaphragm, and so dragging on the growth caused sudden irregular breathing, pain, and shock. The anaesthetist, believing the trouble would soon pass off, simply asked the patient to take deep breaths, which was not possible due to pain. As the anaesthetist was playing to the gallery, having much praised the value of unilateral spinal anaesthesia, he did not want to show that it had failed, so he did not supplement the spinal with any kind of general anaesthesia. This false sense of shame caused the death of the patient.

It is not generally understood that even if the spinal analgesia is as far as the diaphragm or the nipple line, yet the peripheral nerve endings of the vagus in the stomach and diaphragm, if markedly excited by painful stimuli due to pulling on the neck of the stomach as in some cases of gastrectomy, are sometimes enough to lead to sudden fatal reflex cardiac inhibition.

Therefore, I believe that (1) for removal of large growths of kidney, unilateral spinal anaesthesia is inadvisable, and (2) if spinal anaesthesia, unilateral or even bilateral gives any discomfort, general anaesthesia must be then administered to avoid shock which may be fatal.

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#### To the Editor:

Gillespie (Gillespie, N. A.: Surgeon and Anesthetist; Their Mutual Relationship, *J. A. M. A.* 118: 787-790 (Mar. 7) 1942)

has very aptly outlined what the ideal relation should be between surgeon and anesthetist, in order that best results be obtained; in order that the patient be the

gainer rather than the loser during the operation he is being dealt; and in order that the atmosphere of the operating room be kept cheerful and cleared of all static electric charges,—both literally and figuratively.

The following scheme is described to illustrate that a cordial relationship can be developed between neurosurgeon and anesthesiologist in the performance of spinal anesthesia. It indicates that joint anesthesia can be carried out by surgeon and anesthesiologist.

One point of antagonism between surgeon and anesthesiologist is that when one is ready to work, the other is not. This state of affairs sometimes leads to acrimonious remarks with volcanic repercussions. High blood pressures do not promote a steady surgical hand nor are they conducive to the best performance by anesthesiologist or surgical scrub nurse.

If the anesthesiologist in this particular hospital is late in arriving on the scene for a spinal anesthesia with this particular surgeon, the surgeon knows that the anesthesiologist has been detained in getting another anesthesia set up for a simultaneous operation downstairs. Therefore, being a neurosurgeon and adept in lumbar puncture, he

proceeds to perform the lumbar tap and then calmly awaits the anesthesiologist's appearance on the scene, who upon arrival, proceeds to inject the anesthetic drug. The anesthesiologist prepares in a separate syringe the drug remaining in the ampule containing the anesthetic agent. This syringe is turned over to the surgical scrub nurse, who keeps it on her instrument tray for future injection intraspinally, if supplementation is required later on. Such joint management is carried out on operations for removal of intervertebral discs, laminectomies and the like.

Not a bad idea for the busy anesthesiologist who has the good fortune to work with an anesthetic-minded neurosurgeon. Rome was not built in a day nor was it built as a "one man" project, but by joint cooperative effort. The success or failure of any operation depends upon the joint endeavors of all at the operating table, in the sterilizing room, and on the wards.

We are all in the same game. Let's pull together rather than apart.

Very truly yours,  
MAJOR HAROLD F. BISHOP,  
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#### A NEW LARYNGOSCOPE FOR INTUBATION OF INFANTS

At the time the Miller curved laryngoscope for adults was developed, it was thought that a new smaller laryngoscope was also needed for infants. The same pattern has been followed in developing the smaller blade. In infant resuscitation, particularly resuscitation of cesarean babies, intubation is often necessary. It saves many anxious moments for the anesthesiologist for if a tracheal catheter is in place, he has complete control and is able to use suction or administer oxygen. The advantages of the curved laryngoscope for adults has been described by Miller and Cassels. The same advantages apply to the small blade.

Some anesthesiologists and obstetricians can intubate infants blindly by palpating the epiglottis with the finger and fishing the catheter into the trachea through the mouth. When this method is successful it is very

satisfactory, but often it is time consuming, and if it fails, the cords must be visualized by direct vision. If the direct method is 100 per cent accurate, or nearly so, it would seem that a method less efficient should not be considered.

The small laryngoscope blades already on the market are too large and the battery handle too heavy. The size of the present laryngoscope for infants is 10 cm. long, 10 mm. wide, and 10 mm. high. It is recommended that the baby be placed on a table as high as the operating table rather than in a bassinet, since this is the position in which the anesthesiologist is accustomed to work. An assistant should help in holding the head. The blade is inserted in the right side of the mouth, pushing the tongue to the left. The epiglottis is visualized and raised slightly to expose the cords or, if the operator desires, the tip of the blade