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 anesthetist in the performance of spinal anesthesia. It indicates that joint anesthesia can be carried out by surgeon and anesthetist.

One point of antagonism between surgeon and anesthetist 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 anesthetist or surgical scrub nurse.

If the anesthetist in this particular hospital is late in arriving on the scene for a spinal anesthesia with this particular surgeon, the surgeon knows that the anesthetist 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 anesthetist's appearance on the scene, who upon arrival, proceeds to inject the anesthetic drug. The anesthetist 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 anesthetist 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,
Medical Corps,
Army of the United States

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 anesthetist 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 anesthetists 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 anesthetist 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

may be placed in front of the epiglottis and raised sufficiently to visualize the cords after the method of Macintosh. A small

FIGURE 1

catheter size 12 French, 12 cm. in length with a wire stilet inserted, has been found to be most adaptable. After the tube is in place, a glass trap is attached to facilitate suction and administer oxygen. The scope is used for *visualizing* the *cords only*. One should *work outside* the blade to insert the tube. The only criticism of the instrument has been that it is too small through which to work. It was not designed to be used as a guide for the catheter. If this point is

FIGURE 2

kept in mind, the anesthetist, with diligent practice, can become expert in infant intubation.

ROBERT A. MILLER, MD.,
San Antonio, Texas

REFERENCES

1. Cassels, W. H.: Advantages of a Curved Laryngoscope, Anesthesiology 3: 580–581 (Sept.) 1942.
2. Miller, Robert A.: A New Laryngoscope. Anesthesiology 2: 317–320 (May) 1941.
3. Macintosh, R. R.: A New Laryngoscope. Lancet 1: 205 (Feb. 13) 1943.

A METHOD OF ADMINISTERING ETHER-AIR BY CONTINUOUS INSUFFLATION

Surgical procedures about the head in children are fraught with many anesthetic problems. A clear airway may be hard to maintain. Many anesthetists fear intubation because of possible glottic edema during a long operation. The nature of the surgical procedure itself has inconvenienced the anesthetist in establishing and maintaining a free airway since it is important that the surgeon have complete freedom without being hampered by the too close presence of the anesthetist or anesthetic equipment.

If the child is intubated, care must be taken to use a fairly small tube, and to allow no storage of carbon dioxide. Anesthesia apparatus is constructed mainly for adult use and it is difficult to alter it for efficient use in children.

The following apparatus was designed to meet the demands for better anesthesia in children for operations about the head. As