



FIG. 1. Position of sampling catheter within green O₂ mask.

ports of a green disposable oxygen mask to a point close to, but not irritating, the patient's nose. We then secure the catheter to the mask with adhesive tape and connect it to the mass spectrometer sampling tube (fig. 1).

In addition to obtaining satisfactory end-tidal CO₂ es-

Anesthesiology
65:566, 1986

A Modification of Laryngoscopy Technique

To the Editor:—Gandhi and Burgos¹ suggest inserting a detached laryngoscope blade into the mouth when intubating massively obese patients or patients with a barrel-shaped chest or rigid neck, because if attached, the laryngoscope handle may impinge upon the patient's chest. After the blade is in the mouth, the handle is then attached.

We have tried this technique and there are occasions when the laryngoscope handle still impinges upon the

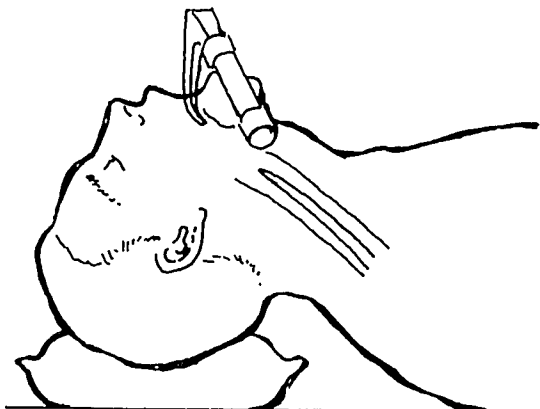


FIG. 1. Modified laryngoscopy technique with blade inserting laterally.

timations in both awake and sedated patients, this technique provides the following advantages: 1) it uses readily available equipment without modification, thus saving time and the reusable sampling tube; 2) the sampling catheter is outside the patient's airway, so it will not be obstructed with secretions, nor will it irritate the patient; and 3) it enables the patient to receive a high oxygen mixture and does not require bilateral patency of the nostrils.

CHARLOTTE T. HUNTINGTON, M.D.
HWA-KOU KING, M.D.
*Department of Anesthesiology
King/Drew Medical Center
12021 South Wilmington Avenue
Los Angeles, California 90059*

REFERENCES

1. Norman EA, Zeig NJ, Ahmad I: Better designs for mass spectrometer monitoring of awake patient. *ANESTHESIOLOGY* 64:664, 1986
2. Ibarra E, Less DE: Mass spectrometer monitoring of patients with regional anesthesia. *ANESTHESIOLOGY* 63:572-573, 1985

(Accepted for publication August 8, 1986.)

chest during attempts to reattach the handle to the blade. We therefore have modified our intubation technique in these patients by turning and lowering the laryngoscope handle toward the right side of the patient's neck and inserting the blade laterally into the mouth (fig. 1) (a tongue blade is usually helpful), then raising and turning the handle forward.

This modification not only saves the time and trouble of detaching and reattaching the laryngoscope blade to the handle, but it also avoids the possibility of having one's finger caught in the hinge.

HWA-KOU KING, M.D.
LONG-FONG WANG, M.D.
AHSANUL K. KHAN, M.D.
*Department of Anesthesiology
King/Drew Medical Center
12021 South Wilmington Avenue
Los Angeles, California 90059*

REFERENCE

1. Gandhi, SK, Burgos, L: A technique of laryngoscopy for difficult intubation. *ANESTHESIOLOGY* 64:528-529, 1986

(Accepted for publication August 8, 1986.)