to know the doses of succinylcholine used in the MMR patients as compared with the "normals," the time interval between the administration of succinylcholine and attempted intubation, and whether jaw tightness was confirmed by a second anesthesiologist.

Because in all but one of the cases in her series the surgery continued, it would appear that jaw relaxation did occur and that intubation was possible. The duration of MMR, therefore, would also be of interest.

While the associations between strabismus surgery, MMR, and MNS remain to be fully elucidated, we agree with the opinion expressed by Rosenberg that (certainly in the strabismus surgical population) succinylcholine is a drug that should now be reserved for specific indications.2

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In Reply.—In our patients with maseter muscle spasm, the average dose of succinylcholine was 1.17 mg/kg, and no patient received more than 1.6 mg/kg. This is a conservative dose, consistent with a dose of 1–2 mg/kg in use in our department at the time. Unfortunately, we cannot report the interval between succinylcholine administration and onset of maseter spasm. Finally, jaw tightness was not consistently confirmed by a second anesthesiologist. The old records are unclear on this point which, of course, is a problem with retrospective chart review.

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Modified Anesthetic Screen for Pediatric Surgery

To the Editor.—The conventional anesthetic screen divides the operating table into two areas; i.e., a clean working area for the surgeon and a working area for the anesthesiologist. The position of the screen is critical when we are working on small infants, especially during tho-

Fig. 1. Modified anesthetic screen positioned on the table.

Fig. 2. Draped screen.

REFERENCES


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A New Device for Fiberoptic Endotracheal Intubation under General Anesthesia

To the Editor—A face mask with diaphragm12 for fiberoptic endotracheal intubation is commercially available. However, cases may arise where such a mask is not immediately available. For such occasions, we have constructed a mask for this purpose using materials that are readily available in an anesthesia workroom. As shown in figure 1, a hole was created in a mask just above the nostril, into which a vinyl cap was tightly fitted. The cap was 15 mm in diameter, with the bottom removed, preserving the edge. Two differently sized rubber fingers were then cut from a surgical glove. The larger of the two was placed on the vinyl cap and the smaller one placed on the proximal end of an endotracheal tube. The cap bearing the rubber finger was then fitted into the mask. Following induction of anesthesia, the rubber fingers were each cut at the tip and the endotracheal tube, through which a fiberoptic bronchoscope was passed, was inserted via the hole into the nostril. The airtight seal around the endotracheal tube and fiberoptic bronchoscope was maintained when the anesthesia bag was squeezed, since the rubber collapsed around the tube and fiber optic bronchoscope due to the positive pressure inside the mask. When the rubber at the proximal end of the endotracheal tube was reflected by pulling back the fiber optic bronchoscope, an airtight seal was easily obtained by lightly pinching the rubber. Although we constructed the present mask for use with the nasal route, the airway intubator could also be used by changing the location of the hole.

Fig. 1. A. Schematic diagram showing the method of making the anesthesia mask for fiber optic endotracheal intubation. B. Proximal end of the endotracheal tube.

REFERENCES