A new metal adapter has been devised to save valuable time in making the necessary connections when intubation has been accomplished. The adapter consists of a metal connection which can be placed between the socket adapter of the face piece and the

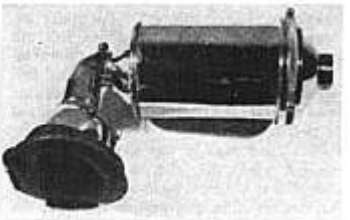

FIG. 1.

canister adapter with nipple inlet, as shown in figure 3. With this setup the change-over from mask to endotracheal catheter is simple and rapid; all that is necessary is to remove the canister adapter from the new connection and place the canister adapter directly on the catheter slip joint. When anesthesia is maintained by face

FIG. 2.

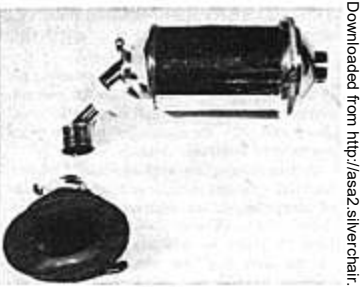

FIG. 3.

mask, the use of this new connection, as shown in figure 4, is preferable to the previous setup (fig. 1) because an extra movable

FIG. 4.

joint permits greater flexibility for maintaining the to-and-fro assembly.

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CORRESPONDENCE

To the Editor:

I am writing to you about some of my experiences in esophageal intubation as worthy of inclusion in the section of Anesthesiology, "Current Comment and Case Reports."

There are several tricks related to the pharynx and esophagus by the use of which the anesthesiologist can facilitate the work of the surgeon.

When it becomes necessary in the course of performing an esophagectomy or transthoracic gastrectomy, a Levin tube can be

passed much more easily indirectly than directly by performing pharyngoscopy with the patient in the lateral position. A well-lubricated nasotracheal tube invariably will pass into the esophagus if the larynx is blocked by a tube lying in the trachea. A lubricated Levin tube can then be passed through the nasotracheal tube in the esophagus, the latter tube being withdrawn so as to leave the Levin tube in place. The Levin tube is then advanced as far as desired.

An esophageal diverticulum may be difficult to locate in the obese or muscular patient with a short neck. The procedure was formerly performed under regional anesthesia so that the sac and esophagus could be identified by swallowing. On one occasion in our experience even this did not help, so that it was necessary to convert the anesthesia to an endotracheal technic, following which the maneuvers to be listed helped to identify the diverticulum. It seems to me that starting with endotracheal anesthesia is more useful; preliminary esophagoscopy under either topical or general anesthesia (intravenous or endotracheal) may or may not be employed to locate the side (usually the left) on which the diverticulum is present and possibly to leave the tip of a stiff urethral catheter in place in the diverticulum. If the latter slips out or has not been in place from the start, a long, well-lubricated nasotracheal tube invariably will pass into the esophagus once it gets beyond the epiglottis and the epiglottic valleculae at the base of the tongue, since it cannot enter the larynx. The tube often appears to seek out the diverticulum, which can be identified by buckling of the tube when resistance is met. If the tube enters the esophagus, which is recognized by passage of the tube to its end without resistance, it may be left in place (later it is useful during closure of the neck of the diverticulum), while a second long nasotracheal tube or any large urethral catheter can be passed blindly or under direct vision, nasally, or orally as desired, to the diverticulum. The latter tube is withdrawn when the surgeon has identified and grasped the diverticulum. The tube lying in the esophagus can be used for the passage of a Levin tube, if desired. Esophagoscopy and diverticuloscopy by the surgeon during the course of the operation are more difficult and unnecessary when compared to these simple maneuvers.

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To the Editor:

The following incident may be of interest to our fellow anesthesiologists as well as operating room supervisors:

A two hour ether-anesthesia by the carbon dioxide absorption method was completed at 10 a.m. At approximately 11 a.m. the used soda lime was dumped into a waste basket which was free of any inflammable material. The waste basket was located in a room where no anesthetic agents were stored or handled, so that the "NO SMOKING" rule was not enforced. At about 11:30 a.m. a passer-by flicked his cigarette ashes (not the stub) into this waste basket and a flame 5 feet high, shot up causing a mild flashburn of the person's hair. The soda lime continued to burn fiercely until extinguished by water.

In my experience this is the first instance in which soda lime which had been out of the operating room for fully half an hour, was a dangerous fire hazard. This incident raises the question, how long can soda lime retain its ether content after having been exposed to air? Used soda lime should be discarded only in places where strict fire prevention rules are enforced.

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