rhage due to severe coughing from tracheal aspiration or the "stir-up" regimen, or both, is not impossible. This case in no way has altered our indications for intercostal block, tracheobronchial suction and the "stir-up" regimen.

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A RECORD HOLDER FOR THE LEFT HANDED ANESTHESIOLOGIST

A problem continually confronting the left handed anesthesiologist is to find stable, convenient support for the anesthesia record while recording data. The record holder * shown in the photograph offers a solution to this problem. The holder incorporates a table rail clamp of standard design, affording ready and rigid support. The writing surface is stainless steel, 1/32 inch thick, measuring 10 inches by 14 inches for ample writing surface. A spring paper holder is riveted securely to the writing surface. The latter is strengthened by a bracket measuring 1/4 inch by 1 inch which extends from the table rail clamp for the entire length of the writing surface.

With minor modifications, this device could be constructed for application on either side of the table to be used by right or left handed persons.

* The author is indebted to the Ohio Chemical and Surgical Equipment Company for construction of this record holder.

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FIG. 1.

ASPIRATION OF FOREIGN BODY DURING ANESTHESIA

A 5 year old boy was admitted to surgery for routine tonsillectomy and adenoidectomy; his medical history and physical examination were satisfactory. Atropine (0.45 mg.) was administered intramuscularly one-half hour before operation. Cyclopropane was used for induction, followed by open drop ether. The induction and maintenance of anesthesia were uneventful.

For tonsillectomies in children a mouth hook is ordinarily used for ether insufflation. However, in this case ether was insufflated

through a number 14 rubber catheter inserted through the right nostril into the posterior pharynx.

Inspection of the pharynx following removal of the right tonsil disclosed that the tip of the rubber catheter had been severed during operation. The pharynx was aspirated and visualized with a laryngoscope, but the search for the missing end of the catheter was unsuccessful. Although the patient showed no symptoms of respiratory difficulty, a roentgenogram was taken; the film revealed a shadow in the right bronchus, the appearance of which suggested that the cut portion had been aspirated.

Anesthesia was deepened, using open drop ether, for bronchoscopic examination. The rubber tip was seen lying in the right upper bronchus and immediately extracted. The patient was returned to his room in good condition and placed on penicillin as a prophylactic measure. His convalescence was uneventful.

COMMENT

When a new or different technique is employed it is important that the anesthesiologist exercise extreme care and be thoroughly familiar with the probable hazards involved.

When it is suspected that a foreign body of the type described has been aspirated and adequate oxygenation has been administered, an exhaustive examination of the operative area should be instituted at once. If the search proves futile, roentgenology should be utilized not only as a routine procedure for the patient's benefit but as individual protection in the event of medicolegal complications.

In this case it was the opinion of one of the attending physicians that perhaps a roentgenologic examination was needless because the patient exhibited no evidence of respiratory distress. However, when it appeared that the tip of the catheter had been severed, insistence on an immediate roentgenologic examination proved to be beneficial.

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A SIMPLE AID FOR INDUCTION OF ANESTHESIA IN CHILDREN

Psychic trauma to the patient is an important problem in pediatric anesthesia. Even with fairly good sedation some children remain quite uncooperative. Screaming, fighting and breath-holding interfere with smooth induction of anesthesia, and the noise proves most unnerving to other patients awaiting operation, and to all the operating room personnel. Many techniques have been developed to render smooth the induction in children; unfortunately some of the better methods, such as basal narcosis by the rectal route, are too cumbersome and time-consuming for routine use in a busy operating schedule.

We have long employed the gravitational method of induction in children. This consists of blowing a large stream of an anesthetic gas over the little patient's face. Either nitrous oxide or cyclopropane is employed. Because these gases are heavier than air, they tend to gravitate toward the patient, and they have little odor to which the child might object. A disadvantage of this method has been that some children refuse even to lie down, and they object to

FIG. 1.

the free end of a rubber hose being held above their face.

To obviate this disadvantage we have incorporated a rubber doll at the end of the tube; the tube is led through the doll and