emerges at its mouth in a nozzle, provided by the bulbous end of a Magill endotracheal connector (see illustration). Almost any child can be persuaded to hold the little toy in its hands, and while playing with such a familiar object the child can more easily be coaxed to lie down. The gases are then turned on while the child looks up at the object it holds. The anesthesiologist may explain that the animal breathes, and so the child raises little objection to the stream of gases playing on its face. While clutching the toy and looking up at it, the patient becomes increasingly drowsy and eventually falls asleep. At this point induction is continued with any of the customary inhalation agents. The amount of gases from the doll is gradually reduced as the mask is lowered onto the patient's face and as the maintenance agent takes hold.

This little contraption has proved extremely helpful, and can be made cheaply from a dime-store rubber doll, a length of rubber tubing to connect with the anesthesia machine, and a Magill endotracheal tube connector.

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DESCRIPTION OF WHITMAN MOUTH GAG *

A new mouth gag for tonsillectomies has been devised which has superseded the old-fashioned "ether hook." The suction apparatus was not changed. The new mouth gag incorporates: (1) an ether inlet tube for insufflation soldered to the upper bracket, with the nipple at the handle of the gag, and (2) an oxygen inlet tube soldered to the lower bracket or arm of the mouth gag. Instead of attaching the tubing to the "hooked type" insufflator, it is attached directly to the mouth gag. Oxygen is delivered from the usual source.

The mouth gag has been employed in a series of 800 tonsillectomies in patients ranging in age from 19 months to 11 years. With oxygen flowing at a rate of 1500 cc. per minute (following removal of adenoids), the reaction time was definitely decreased; it ranged from twelve to twenty minutes, proportional to the operating time. Therefore, the hypoxia which is present during a prolonged reaction time was not encountered. During the immediate postoperative period, with the mouth gag closed and oxygen still being administered, when the first episode of vomiting occurred, the vomitus was easily aspirated.

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* The mouth gag was made to the author's specifications by the Sklar Instrument Company.

CORRESPONDENCE

To the Editor:

To provide efficient and inexpensive grounding of operating room personnel, the following procedure has been found valuable: An aluminum strip from an intravenous infusion bottle has been bent so that it will touch the sock inside the shoe and then make contact with the floor at the broad part of the heel, as indicated in figure 1. The conductivity is then tested by use of the device described by Hickcox, Tovell and Lovell in ANESTHESIOLOGY 12: 506 (July) 1951. This device indicated that most leather shoes are not of themselves adequately conductive. Most commercial conducting strips for shoes are expensive, especially when operating room personnel changes rapidly, as in our teaching institution. Most conducting strips discolor stockings. Many of them do not fit an unconventional type of heel. The aluminum strips are satisfactory as shown unless the wearer has an especially thick sock, in which case he can fold the aluminum inside the sock or wet the sock.

Doctor George J. Thomas of Pittsburgh,

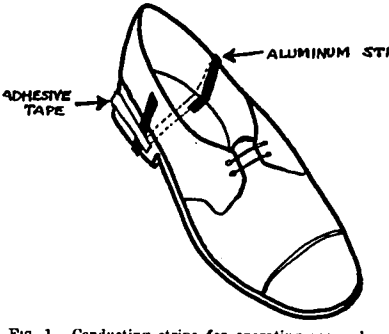

FIG. 1. Conducting strips for operating room shoes.

writes, "We were unable to produce sparks with the aluminum strip even on a very hard vitreous ceramic tile floor. The conductivity is rapid and thorough with this method."

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To the Editor:

Recently an explosion occurred as a complication of pentothal®-oxygen administration, which rocked the anesthesia world (1). There are, of course, many possible ways whereby cyclopropane, ether, ethylene, and so forth might come to be present in the apparatus or area, where the anesthetist thought the explosion hazard could not arise. With a lighted match held close to the anus at the psychological moment, the flammability of bowel gas can readily be demonstrated but the incidence of explosions is not such that one can accept this as a factor of clinical importance to the anesthetist.

The purpose of this communication is to direct attention to certain important but little known features of the thiobarbiturates, which may have a bearing on the incident mentioned above.

When a solution of a thiobarbiturate is prepared for intravenous injection, it exhibits a characteristic odor. If induction is rapid, that is, by forcible delivery through a 15 gauge needle of approximately 0.5 Gm. (5 per cent solution), there follows, in extreme form, the hypernea which is the great hazard with these agents (2). The successive powerful expirations throw off the same odor as does the solution before injection, showing that the lungs have a relationship to the fate of these drugs in the body.

The influence of pulmonary excretion and the mechanisms of water ejection on the elimination of intravenous barbiturates and the duration of their action may repay serious study. However, in view of the explosion hazard, it must be remembered that many forms of sulfur are flammable, so it is possible that the odor from the lungs is that of an explosive gas. Remote though it seems, there is, too, the possibility that brimstone released into the lungs may irritate the respiratory epithelium.

Although the complications of anesthesia are fully discussed elsewhere (2), it must be mentioned here that unless *scrupulous and effective* measures are *first* taken to clear the respiratory passages and the upper digestive tract, the production of hypernea (with the barbiturates) invites a fatality.

REFERENCES

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