

CURRENT COMMENT AND CASE REPORTS

CURRENT COMMENT is a section in ANESTHESIOLOGY in which will appear invited and unsolicited professional and scientific correspondence, abbreviated reports of interesting cases, material of interest to anesthesiologists reprinted from varied sources, brief descriptions of apparatus and appliances, technical suggestions, and short citations of experiences with drugs and methods in anesthesiology. Contributions are urgently solicited. Editorial discretion is reserved in selecting and preparing those published. The author's name or initials will appear with all items included.

ANESTHESIA EQUIPMENT KITS

In this hospital anesthetic procedures are carried out in cystoscopy rooms, X-ray department, emergency ward, and in other locations at a considerable distance from the main anesthesia supply room. The need for a compact portable anesthesia kit has long been experienced. Various small kits have been improvised from time to time.

A suitable container for a standard unit could not be purchased. A wooden box measuring 8 1/2 inches by 8 1/2 inches by 16 inches was constructed of 1/2 inch maple (Fig. 1). The cover is 2 inches in height and hinged to open backward. A hinged T support is attached to the handle to prevent the box from tilting when the top tray is placed in the open cover.

Two trays, each measuring 1 3/4 inches in depth, occupy the top portion of the chest (Fig. 2). They are made of 5/16 inch maple with the bottom of 1/8 inch Masonite. The compartments are separated by partitions of 1/4 inch plywood. The lower tray is supported by 5/16 inch maple cleats fastened to the inner surface of the chest, and the upper tray is supported by the lower tray. The ampules are mounted on an adhesive backing, as described by Sanford (1).

When the kit is in use, the top tray is placed in the open cover (Fig. 3). After the required items from the lower compartment have been removed the lower tray is replaced. Any needed items are then readily accessible.

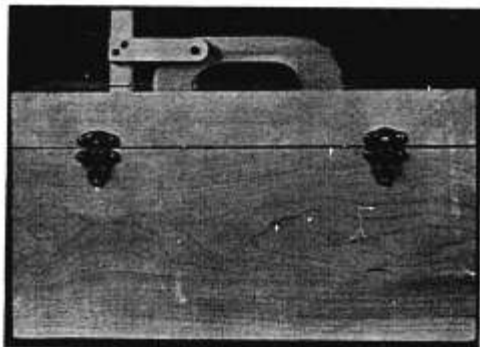


FIG. 1. Anesthesia equipment chest.

Standard items and their arrangement are as follows:

Top Tray

Ampule Section (from left to right)

- 1 Amyl nitrite
- 2 Ephedrine sulfate, 40 mg.
- 2 Epinephrine, 1 cc., 1/1,000
- 2 Neosynephrine, 10 mg.
- 2 Pitocin, 10 units
- 2 Prostigmine, 0.5 mg.
- 2 Vasoxyl, 20 mg.

Left Section

- Safety pins
- Cork for ether dropping
- Atropine solution—rubber capped vial

Left Center Section

- 5 cc. syringe, sterile
- Pontocaine ointment
- Spring paper clip and intravenous clamp
- 2 Ampules nembutal solution, 0.25 Gm.

Right Center Section

- 1 Ampule d-tubocurarine solution
- 1 2 cc. syringe, sterile
- 1 Roll of 1 inch adhesive tape
- 1 Spring pinchcock

Right Section

- 2 Needles, No. 18, sterile
- 1 Pack tongue depressors
- 1 Metal connector for suction
- 1 10 cc. syringe for cuff inflation
- 1 Syringe adapter for cuff inflation
- 1 Tourniquet

Lower Tray

Left Front Section

Laryngoscope

Center Front Section

Y connection

Saunders elbows 8, 9, 10, 11 mm. sizes

Right Front Section

Adult airway

Child airway

Right Rear Section

Rovenstine right angle elbow

Slip joints—assorted sizes, 6 to 11 mm.

Left Rear Section

- 4 Magill tubes oral (assorted sizes)
- 2 Tovell tubes, 1 No. 34, 1 No. 32
- 1 Portex tube, No. 8
- 2 Mouth props, gauze
- 1 Beechwood stick

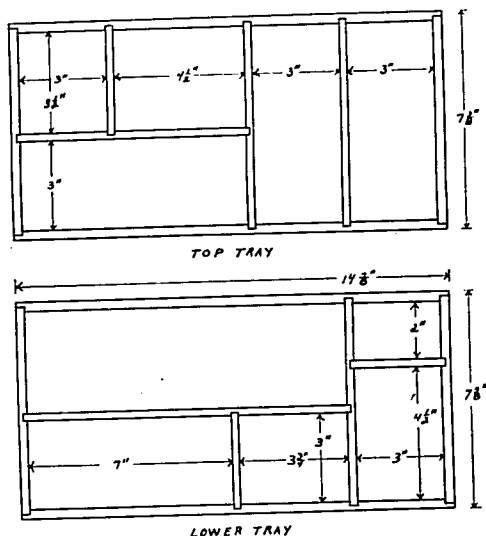


FIG. 2. Tray dimensions.



FIG. 3. Kit open, ready for use.

- 1 MacIntosh laryngoscope blade
- 2 Saunderson's cuffs, 1 large, 1 medium
- 2 Aspirating catheters
- 2 Nasopharyngeal tubes
- 1 Stilette with rubber stopper

Lower Compartment

Masks: Large, medium and small
Sphygmomanometer and Stethoscope

These units have been in use for the past two years and have proved satisfactory. Each of our residents is provided with one

of these kits. A recent improvement has been the substitution of a drawer in the bottom of the chest for the top tray.

REFERENCE

1. Sanford, C. H.: Visible Ampules, *Anesthesiology* 5: 303 (May) 1944.

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A NEW NASOPHARYNGEAL AIRWAY

Upper or supraglottic respiratory obstruction may occur as the result of anesthesia, foreign body or disease. In the absence of a foreign body or tumor, the

obstruction is usually the result of relaxed pharyngeal musculature, associated with decreased tonus of the muscles supporting the jaw. The base of the tongue ap-