CURRENT COMMENT AND CASE REPORTS

CURRENT COMMENT is a new department in ANESTHESIOLOGY. In it will appear invited 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.

CONSULTATION RECORD FOR INHALATION THERAPY

The ever increasing significance of the problems of hypoxia and asphyxia is being rapidly appreciated in most hospitals of the country. The necessity for providing immediate and adequate measures for resuscitation and oxygen therapy and for centralizing their control in proper hands has now become obvious. Army hospitals are no different from civilian institutions in this respect. A separate section for such services was organized at the Tilton General Hospital, Fort Dix, New Jersey (1), shortly after its official opening last summer.

To facilitate the function of this section in properly recording and evaluating treatments administered, a special consultation record was devised (illustration 1). Its use throughout the year has been found particularly valuable.

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REFERENCE

1. Martin, Stevens J., Major M.C., and Makel, Col. Hertel P.: Organization of a Section on Resuscitation and Oxygen Therapy, Army Med. Bull., No. 61 (April) 1942.

CONSULTATION RECORD

RESUSCITATION AND OXYGEN THERAPY SECTION

Date:.....

Surgical Service
Tilton General Hospital
Fort Dix, N. J.

I. NAME OF PATIENT:.....GRADE:.....AGE:.....WARD:.....
Consultation requested by.....Med:.....Dent:.....Surg:.....Pre:.....Postop:.....
Reason for consultation:.....
Diagnosis:.....

II. RESUSCITATION:
A. Maintenance of Respiration — *Time*
1. Airways: Natural.....Artif: Oral.....Nasal.....Endotr.....Begin.....End.....
2. Manual: Silvester....., Schafer..... " ..... " .....
3. Inflation of chest: Closed CO_2 absorption technique..... " ..... " .....
4. Drinker-Collins Respirator "Iron Lung":..... " ..... " .....
B. Maintenance of Cardiovascular System
1. Drugs used:.....Dose:.....
2. Intravenous fluids: Infusions.....Transfusions.....

III. OXYGEN THERAPY:

A. Method Employed	*Flow/min.*	*Time*
1. BLB nasal mask	:	Begin.....End.....
2. Catheter: nasal.....oral:	:	" ..... " .....
3. Endotracheal	:	" ..... " .....
4. Others	:	" ..... " .....

IV. OTHER GASES:

		Time
A. Helium.....Method used:	:	Begin.....End.....
B. Helium and oxygen.....Method used:	:	" ..... " .....
C. Carbon dioxide.....Method used:	:	" ..... " .....

V. SUMMARY:

A. Evaluation of treatment

1. Recovery.....2. Partially effective.....3. No effect.....

B. Reason for failure.....

C. Recommendations.....

Anesthetist.....

ILLUSTRATION 1. Consultation record for inhalation therapy.

ADVANTAGES OF A CURVED LARYNGOSCOPE

In many things in medicine tradition has obscured the advantages of modifications in technic and design. This is true of certain instruments such as the laryngoscope. Bronchoscopists designed laryngoscopes suitable for their purposes, particularly for the insertion of other long, straight instruments such as the bronchoscope. Anesthetists, finding exposure of the larynx useful for the insertion of endotracheal tubes, designed their laryngoscopes on the model of those used by the bronchoscopist. Gradually modifications have been developed but it is remarkable how we still adhere to traditional features. For example, many of our laryngoscopes are still "C" shaped in cross section rather than having the open edges come out straight. This is probably a carry over from the bronchoscopist's instrument which has a sliding piece to fit the gap and complete the circle.

The procedure of inserting a bronchoscope differs from that of inserting an endotracheal tube. The bronchoscope, being straight and rigid, must be inserted directly in line with the trachea and is therefore introduced straight down the laryngoscope. The bronchoscopist can view the larynx through the bronchoscope. The endotracheal tube, on the other hand, being curved and flexible, can usually be passed through the mouth at the right side of the laryngoscope, only the tip coming to the mid-line as it approaches the larynx. This affords the anesthetist a view of the larynx through the laryngoscope which he cannot get through the curved tube. These differences in technic indicate differences in design of the two instruments.

We have found that a curved laryngoscope provides a better exposure of the larynx. The curve does not interfere with the anesthetist's view. The design used as compared with a similar straight laryngoscope is illustrated in the figure.

In 1913 Janeway (1) suggested the use of a curved laryngoscope for the introduction of endotracheal tubes. His object was to direct the tube through the laryngoscope and thus get a "slight forward bend of the catheter" to direct it into the larynx. This is not the object we have in using the curved laryngoscope since we depend on the natural curve of the tube or on a curved stilet to produce the forward bend into the larynx, and we try not to pass it through the laryngoscope. Miller, in 1941 (2), described a laryngoscope with a curve 2 inches from the distal end. The other features of the Miller laryngoscope make it considerably different from those in general use, and the value of the curve