

to know the doses of succinylcholine used in the MMR patients as compared with the "normals," the time interval between the administration of succinylcholine and attempted intubation, and whether jaw tightness was confirmed by a second anesthesiologist.

Because in all but one of the cases in her series the surgery continued, it would appear that jaw relaxation did occur and that intubation was possible. The duration of MMR, therefore, would also be of interest.

While the associations between strabismus surgery, MMR, and MHS remain to be fully elucidated, we agree with the opinion expressed by Rosenberg that (certainly in the strabismus surgical population) succinylcholine is a drug that should now be reserved for specific indications.⁷

NATHAN SCHWARTZ, M.D.
Assistant Professor of Anesthesiology and Pediatrics

JAMES B. EISENKRAFT, M.D.
*Associate Professor of Anesthesiology,
Director, Anesthesia Research*

EDWARD L. RAAB, M.D.
*Professor of Ophthalmology and Associate Professor of
Pediatrics*

Anesthesiology
69:636, 1988

In Reply:—In our patients with masseter muscle spasm, the average dose of succinylcholine was 1.17 mg/kg, and no patient received more than 1.6 mg/kg. This is a conservative dose, consistent with a dose of 1–2 mg/kg in use in our department at the time. Unfortunately, we cannot report the interval between succinylcholine administration and onset of masseter spasm. Finally, jaw tightness was not consistently confirmed by a second anesthesiologist. The old records are unclear on this point which, of course, is a problem with retrospective chart review.

Anesthesiology
69:636–637, 1988

Modified Anesthetic Screen for Pediatric Surgery

To the Editor:—The conventional anesthetic screen divides the operating table into two areas; i.e., a clean working area for the surgeon

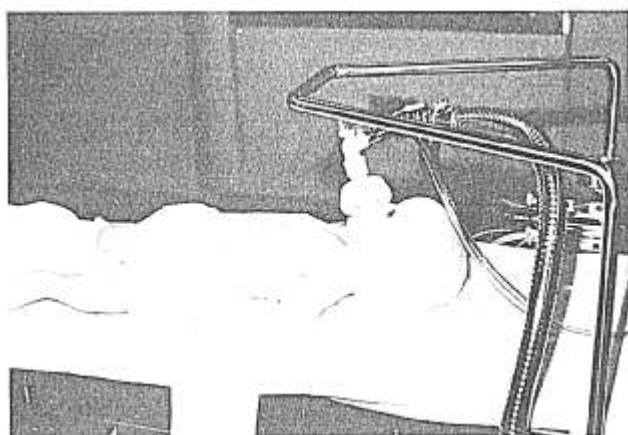


FIG. 1. Modified anesthetic screen positioned on the table.

Mount Sinai School of Medicine
of the City University of New York
New York, New York 10029

REFERENCES

1. Carroll JB: Increased incidence of masseter spasm in children with strabismus anesthetized with halothane and succinylcholine. *ANESTHESIOLOGY* 67:559–561, 1987
2. Rosenberg H, Fletcher JE: Masseter muscle rigidity and malignant hyperthermia susceptibility. *Anesth Analg* 65:161–164, 1986
3. Ellis FR, Halsall PJ: Suxamethonium spasm: A differential diagnostic conundrum. *Br J Anaesth* 56:381–383, 1984
4. Schwartz L, Rockoff MA, Koka BV: Masseter spasm with anesthesia: Incidence and implications. *ANESTHESIOLOGY* 61:772–775, 1984
5. Lincoff HA, Breinin GM, De Voe AG: The effect of succinylcholine on the extraocular muscles. *Am J Ophthalmol* 43:440–444, 1957
6. Mindel JS, Raab EL, Eisenkraft JB, Teutsch G: Succinylcholine-induced return of the eyes to the basic deviation. *Ophthalmology* 87:1288–1295, 1980
7. Rosenberg H: Trismus is not trivial (editorial). *ANESTHESIOLOGY* 67:453–455, 1987

(Accepted for publication June 23, 1988.)

JOAN B. CARROLL, M.D.
*Department of Anesthesiology
The University of Tennessee, Memphis
One Children's Plaza
Memphis, Tennessee 38103-2883*

(Accepted for publication June 23, 1988.)

and a working area for the anesthesiologist. The position of the screen is critical when we are working on small infants, especially during tho-

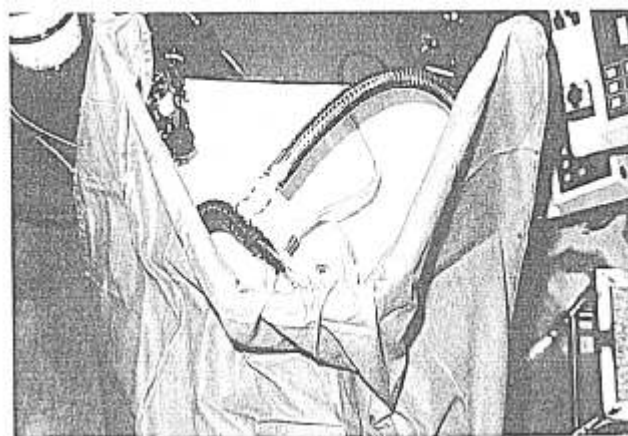


FIG. 2. Draped screen.

racic surgery procedures. The surgeon wants to keep the screen away from the operating field, while the anesthesiologist wants to position the screen over the neck of infant so that the face of the infant and endotracheal tube can be observed. The conventional L-shape screen positioned over the neck of the infant tends to disturb the movement of the arm and elbow of the surgeon.

A slight change of the shape of the screen has resolved this problem in our operating rooms.

The horizontal portion of the screen was replaced by a trapezoid-shaped bar (fig. 1). The plane of the trapezoid crosses the vertical pole at right angles. The screen is positioned so that the head and neck of

the infant can be viewed from above (fig. 2). With this arrangement, there is much more room for surgeons on either side of the neck, while the anesthesiologist can still directly observe and have access to the infant without disturbing the surgeon.

MASAO YAMASHITA, M.D.
Anesthetist-in-Chief
Ibaraki Children's Hospital
Mito, 311-41, Japan

(Accepted for publication June 23, 1988.)

Anesthesiology
69:637, 1988

A New Device for Fiberoptic Endotracheal Intubation under General Anesthesia

To the Editor:—A face mask with diaphragm^{1,2} for fiberoptic endotracheal intubation is commercially available. However, cases may arise where such a mask is not immediately available. For such occasions, we have constructed a mask for this purpose using materials that are readily available in an anesthesia workroom. As shown in figure 1, a hole was created in a mask just above the nostril, into which a vinyl cap was tightly fitted. The cap was 15 mm in diameter, with the bottom removed, preserving the edge. Two differently sized rubber fingers were then cut from a surgical glove. The larger of the two was placed on the vinyl cap and the smaller one placed on the proximal end of an endotracheal tube. The cap bearing the rubber finger was then fitted into the mask. Following induction of anesthesia, the rubber fingers were each cut at the tip and the endotracheal tube, through which a fiberoptic bronchoscope was passed, was inserted *via* the hole into the nostril. The airtight seal around the endotracheal tube and fiberoptic bronchoscope was maintained when the anesthesia bag was squeezed, since the rubber collapsed around the tube and fiberoptic bronchoscope due to the positive pressure inside the mask. When the rubber at the

proximal end of the endotracheal tube was reflected by pulling back the fiberoptic bronchoscope, an airtight seal was easily obtained by lightly pinching the rubber. Although we constructed the present mask for use with the nasal route, the airway intubator could also be used by changing the location of the hole.

MASAHITO OKUDA, M.D.
Assistant Professor

KEIJI HIRANO, M.D.
Assistant Professor

HIROFUMI UTSUNOMIYA, M.D.
Assistant Professor

KUNIHIKO KONISHI, M.D.
Associate Professor

MANNOSUKE MUNEYUKI, M.D.
Professor

Department of Anesthesiology
Mie University, School of Medicine
Tsu, Mie 514, Japan

JUN MATSUMOTO, D.D.S.
Assistant Professor
Department of Oral Surgery
Mie University, School of Medicine
Tsu, Mie 514, Japan

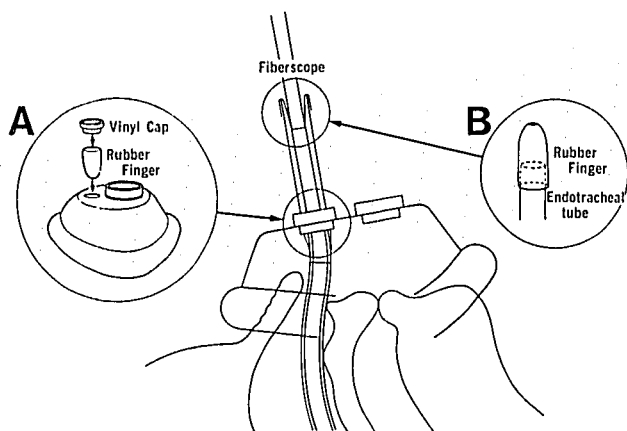


FIG. 1. A. Schematic diagram showing the method of making the anesthesia mask for fiberoptic endotracheal intubation. B. Proximal end of the endotracheal tube.

REFERENCES

1. Patil V, Stehling LC, Zauder ML, Koch JP: Mechanical aids for fiberoptic endoscopy. *ANESTHESIOLOGY* 57:69-70, 1982
2. Rogers SN, Benumof JL: New and easy techniques for fiberoptic endoscopy-aided tracheal intubation. *ANESTHESIOLOGY* 59: 569-572, 1983

(Accepted for publication July 6, 1988.)