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.

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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.

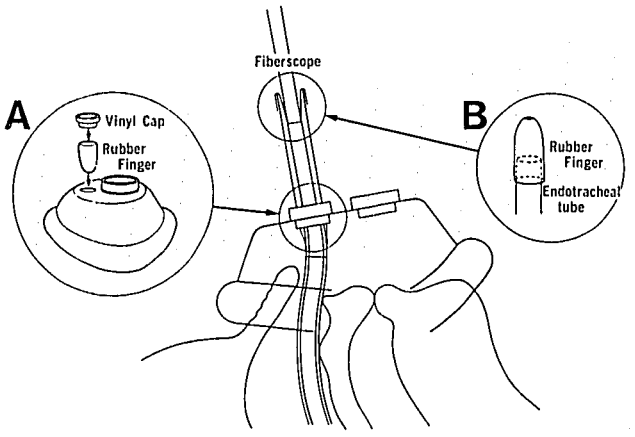

FIG. 1. *A.* Schematic diagram showing the method of making the anesthesia mask for fiberoptic endotracheal intubation. *B.* Proximal end of the endotracheal tube.

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