hence when the patient again may face an anesthetic induction.

**SUMMARY**

A rapid, pleasant, nonfrightening method of induction of pediatric anesthesia, using a transparent plastic “space helmet” ‡ and cyclopropane and oxygen is presented. For children varying in age from 2 years to 13 years, anesthesia can be induced by this method in a period of time ranging from thirty seconds to two minutes without fear or fright. Unpleasant memories of anesthetic induction can be eliminated, thus making the individual more agreeable to any anesthetic procedure in later life.

CDR Douglas J. Giorgio, MC, USN,§
Chief, Department of Anesthesia,
CDR John V. Ninanen, DC, USN,
Chief, Prosthodontics Service,
Lt. John G. Morrow, Jr., MC, USNR,∥
Department of Anesthesia,
United States Naval Hospital,
National Naval Medical Center,
Bethesda, Maryland

‡ Present address: D. J. Giorgio, M.D.,
1018 Lincoln Avenue, Evansville, Indiana.
∥ Present address: John G. Morrow, M.D.,
Presbyterian Hospital, Charlotte, North Carolina.

---

**A SIMPLE EMERGENCY POSITIVE OXYGEN PRESSURE TECHNIQUE**

One of the more distressing and crucial emergencies which arise in the admitting room or on the wards in everyday hospital practice is the problem of respiratory failure or severe respiratory depression. Since it is often difficult to obtain immediately an iron lung or other positive pressure device, and it is always tedious, if not ineffective, to employ manual techniques for pulmonary ventilation, an extremely simple but effective temporary maneuver was devised to obtain positive pressure artificial respiration rapidly in cases of respiratory failure.

**TECHNIQUE**

The only equipment necessary for employment of this technique is any standard pressure source of oxygen or air, and a 6-inch strip of wide adhesive tape. The patient is placed in either a prone or sitting position and a nasal catheter from the gas source being used is inserted through the nose in the usual fashion. The strip of adhesive is firmly applied across the patient’s mouth to seal his lips. The physician then alternately closes and opens the nares by clamping his fingers sideways to the fleshy portion of the patient’s nose. When the lung is expanded, the fingers are released and the patient passively ex-
failure or insufficiency responsive to artificial respiration.

ACKNOWLEDGMENT

I wish to express my gratitude to Dean Gordon Scott, Wayne University College of Medicine, for aid, enabling me to complete this problem.

J. B. ROSENBAUM, M.D.,
Wayne University Medical School,
Detroit, Michigan

CORRESPONDENCE

To the Editor:

We present the following illustration to show the unusual size which laryngeal granulomas may attain. The patient was a 19 year old girl with quiescent pulmonary tuberculosis who underwent a segmental resection of the upper lobe of the right lung and plombage. Her voice was clear and at intubation the vocal cords appeared normal. Ether was administered for three hours through a 32 French woven silk endotracheal tube with cuff. From the first postoperative day the patient noticed increasing hoarseness, cough and progressive difficulty in breathing, especially when going to sleep. Three months later, bilateral granulomas of the cords, which arose by short stalks just posterior to the tips of the vocal processes of the arytenoid cartilages, were removed by snare and forceps. The growths have not recurred twenty months after their removal.

Pathologic examination proved the granulomas to be granulation tissue attributable to nonspecific inflammation. Serial sections of the growths showed no tuberculous foci.

CLEMENT S. DWYER, M.D.,
PHILIP B. THOMAS, M.D.,
WARREN G. STROUT, M.D.,
Department of Anesthesiology,
Eastern Maine General Hospital,
Bangor, Maine