A MODIFIED LARYNGOSCOPE BLADE

During the past few years, while teaching student anesthetists, it was noted that beginners were frequently confused as to which hand to use with the laryngoscope and which hand to use to pass the endotracheal tube. Frequently a student would use the right hand to insert the scope, then change hands on the scope and pass the tube also with the right hand. This is awkward as the scope is generally made to be used with the left hand and changing hands sometimes causes loss of visualization of the larynx, and also consumes more time.

For these reasons, a scope blade (fig. 1) was designed which can be used equally well with either hand. While designing this scope, several minor modifications were developed which appeared to be advantageous. The twin lights give greater light intensity and overcome to some extent the irritating complication of pharyngeal mucus covering the light bulb and decreasing the visualization.

Fig. 1. Laryngoscope blade of author’s design to fit folding scope.
Artist: Charles Freeman.

* The laryngoscope blade may be purchased from the Foregger Company, New York, New York.
tion of the field. The trough arrangement of the shaft of the blade acts as a guide for the endotracheal tube and yet does not bind on the tube. The tip is somewhat narrow and curves backward. This allows for easy access to the epiglottis in patients who have a deep, narrow pharynx and also lifts the epiglottis without excess pressure on the base of the tongue.

**Summary**

A new modification of the Laryngoscope designed for use with either the right or left hand is presented to the anesthesiologist for his appraisal.

Paul W. Searles, M.D.,
215 Beard Ave.,
Buffalo, New York

---

**CURLARE IN TORTICOLLIS**

Torticollis, more commonly known as wryneck, is a syndrome of unknown origin characterized by tonic or tonic-clonic spasm of the neck muscles, sternomastoid and trapezius, with resulting deviation of the head. The congenital form, which is usually the result of a birth injury or some other obscure cause, is not considered here. We are solely concerned with the acquired adult form, and particularly that associated with an etiology of severe or prolonged strain, or possibly of psychogenic origin.

A 24-year-old, white nurse had a severe torticollis of two days' duration. During those two days she was treated with sedatives, diathermy, wet heat, codeine, and aspirin, and infusions of procaine-ascorbic acid, none of which offered any relief. She was taken to the operating room, where the necessary intubating and resuscitating apparatus was available, and intostrin was slowly administered intravenously. The administration was continued until the patient complained of great difficulty in swallowing and some slight difficulty in breathing. The complaint of double vision is given very early and disregarded. A total of 100 units of intostrin was given. Intubation was not performed and medication was not given. After twelve minutes the patient complained only of the doublevision, the breathing and swallowing not being the least bit bothersome. At this time there was complete relaxation of the neck muscles. She was able to move her neck in all directions easily, and there was no pain. She was then given 40 units of intostrin intramuscularly, for slow absorption, and returned to her room. She was discharged that afternoon, completely cured, and returned to her nursing duties the following morning. There has been no recurrence at this writing, more than a month after treatment.

A 25-year-old, white, obese woman had severe torticollis of one day's duration. She refused hospitalization. This patient was definitely of the hysterical type. Resuscitation and intubation apparatus being available, it was decided to give curare in the office. After carefully explaining to the patient that she would experience double vision and some difficulties in swallowing and respiration, tubarine was given intravenously very slowly. After the administration of 6 mg. (2 cc.) of the tubarine, the patient experienced some slight changes in swallowing and double-vision and became somewhat hysterical. Administration of tubarine was discontinued. After several minutes she quieted down and said that her neck felt better. On testing, it was found that a great deal of the mobility had returned, and some pain was present only on extreme lateral rotation of the head. Tubarine, 6 mg., was given intramuscularly. Several hours later the patient reported complete relief in all respects. There has been no recurrence at this writing, three weeks after treatment.

In producing paralysis of the skeletal musculature, curare affects the muscles of the neck early, that is before it paralyzes the intercostal muscles, diaphragm, long muscles of the back or muscles of the extremities. It has a definite indication in acquired torticollis and undoubtedly merits further study.

S. M. Lilienfeld, M.D.,
Associate Attending in Anesthesia,
Rockaway Beach Hospital,
Rockaway Beach, N. Y., and
Robert A. Berman, M.D.,
Associate-in-charge of Anesthesia,
St. Joseph's Hospital,
Far Rockaway, N. Y.