CURRENT COMMENT AND CASE REPORTS

CURRENT COMMENT is a section in Anesthesiology in which will appear invited and unsolicited 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.

A PANEL FOR ANESTHESIA EQUIPMENT

The anesthesiologist’s armamentarium has increased so steadily during the past few years that additional working and storage space seems almost mandatory. The conventional hodgepodge of masks, tubes and laryngoscopes piled high on the

![Image of a panel with equipment]

**Fig. 1.** The panel with equipment.

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cabinet or machine is a definite hindrance to rapid and accurate work. An extra cabinet takes up more precious floor space and usually puts some of the equipment out of quick reach.

A vertical panel fastened to the back of the cabinet or machine solves the problem effectively and inexpensively. The one shown is made of 5/8 inch plywood and is approximately 2 feet square. The left upper portion of the panel carries two small shelves edged with aluminum strip to keep the contents in place when the cabinet is moved about. The upper right portion contains the laryngoscope holders. These were chosen after considerable experimentation; they are 2 1/2 inch lengths of 1 1/8 inch chromium-plated brass pipe. This is obtainable in most hardware stores; it is commonly used as the drainpipe for wash basins and kitchen sinks. The left middle portion of the panel carries five or six chromium-plated coat hooks for masks, while the bottom portion holds two boxes, one for straight endotracheal tubes and one for curved tubes. Convenient dimensions for the first box (inside) are 3 inches by 3 inches by 14 inches. The box for the curved tubes need not represent the complete traditional circle of 7 inch diameter; an arc sufficient to accommodate 13 inch tubes is adequate. This box is also 3
inches deep, and both have hinged lids. The arrangement of the panel is a personal matter and probably no two anesthesiologists would design identical panels. The sphygmomanometer and the water manometer might well be included.

Another possibility is an ampule rack for the more frequently used drugs.

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CART WITH NONDETACHABLE RESTRAINT STRAP

This cart is made by taking the ordinary hospital operating room cart and having the hospital engineer cut a rectangular hole $\frac{1}{2}$ inch by $2\frac{1}{2}$ inches between the ends and on each edge of the cart. A belt buckle arrangement is made, as illustrated, and riveted to the cart. The advantages are as follows:

1. The belts are never lost, used for other purposes, or left in the patient's room.

2. Heavily medicated patients are reminded the gurney is narrow and are mildly restrained on the cart, thus preventing falls and injuries.

3. If the anesthesiologist administers the anesthetic in an anesthetic room he may do so on the cart with some control during the excitement period.

4. Postanesthetic excitement stages which occur when the patient regains his reflexes in the operating room are more easily restrained on the way to the room.

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THE COUGH TEST FOR DETERMINATION OF LEVEL OF SPINAL ANESTHESIA

I have been using the cough as a means of determining the height of abdominal muscle relaxation under spinal anesthesia for the past two years. In the absence of any mention of this test in the literature on spinal anesthesia for which I have searched, I believe this clinical note might be helpful and new to many anesthesiologists. It is the sort of idea, however, which many experienced anesthetists must have discovered for themselves. Therefore, no claim for originality is intended by this report.