through a number 14 rubber catheter inserted through the right nostril into the posterior pharynx.

Inspection of the pharynx following removal of the right tonsil disclosed that the tip of the rubber catheter had been severed during operation. The pharynx was aspirated and visualized with a laryngoscope, but the search for the missing end of the catheter was unsuccessful. Although the patient showed no symptoms of respiratory difficulty, a roentgenogram was taken; the film revealed a shadow in the right bronchus, the appearance of which suggested that the cut portion had been aspirated.

Anesthesia was deepened, using open drop ether, for bronchoesoscopic examination. The rubber tip was seen lying in the right upper bronchus and immediately extracted. The patient was returned to his room in good condition and placed on penicillin as a prophylactic measure. His convalescence was uneventful.

**Comment**

When a new or different technique is employed it is important that the anesthesiologist exercise extreme care and be thoroughly familiar with the probable hazards involved.

When it is suspected that a foreign body of the type described has been aspirated and adequate oxygenation has been administered, an exhaustive examination of the operative area should be instituted at once. If the search proves futile, roentgenology should be utilized not only as a routine procedure for the patient's benefit but as individual protection in the event of medicolegal complications.

In this case it was the opinion of one of the attending physicians that perhaps a roentgenologic examination was needless because the patient exhibited no evidence of respiratory distress. However, when it appeared that the tip of the catheter had been severed, insistence on an immediate roentgenologic examination proved to be beneficial.

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**A Simple Aid for Induction of Anesthesia in Children**

Psychic trauma to the patient is an important problem in pediatric anesthesia. Even with fairly good sedation some children remain quite uncooperative. Screaming, fighting and breath-holding interfere with smooth induction of anesthesia, and the noise proves most unnerving to other patients awaiting operation, and to all the operating room personnel. Many techniques have been developed to render smooth the induction in children; unfortunately some of the better methods, such as basal narcosis by the rectal route, are too cumbersome and time-consuming for routine use in a busy operating schedule.

We have long employed the gravitational method of induction in children. This consists of blowing a large stream of an anesthetic gas over the little patient's face. Either nitrous oxide or cyclopropane is employed. Because these gases are heavier than air, they tend to gravitate toward the patient, and they have little odor to which the child might object. A disadvantage of this method has been that some children refuse even to lie down, and they object to the free end of a rubber hose being held above their face.

To obviate this disadvantage we have incorporated a rubber doll at the end of the tube; the tube is led through the doll and
emerges at its mouth in a nozzle, provided by the bulbous end of a Magill endotracheal connector (see illustration). Almost any child can be persuaded to hold the little toy in its hands, and while playing with such a familiar object the child can more easily be coaxed to lie down. The gases are then turned on while the child looks up at the object it holds. The anesthesiologist may explain that the animal breathes, and so the child raises little objection to the stream of gases playing on its face. While clutching the toy and looking up at it, the patient becomes increasingly drowsy and eventually falls asleep. At this point induction is continued with any of the customary inhalation agents. The amount of gases from the doll is gradually reduced as the mask is lowered onto the patient’s face and as the maintenance agent takes hold.

This little contraption has proved extremely helpful, and can be made cheaply from a dime-store rubber doll, a length of rubber tubing to connect with the anesthesia machine, and a Magill endotracheal tube connector.

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DESCRIPTION OF WHITMAN MOUTH GAG *

A new mouth gag for tonsillectomies has been devised which has superseded the old-fashioned “ether hook.” The suction apparatus was not changed. The new mouth gag incorporates: (1) an ether inlet tube for insufflation soldered to the upper bracket, with the nipple at the handle of the gag, and (2) an oxygen inlet tube soldered to the lower bracket or arm of the mouth gag. Instead of attaching the tubing to the “hooked type” insufflator, it is attached directly to the mouth gag. Oxygen is delivered from the usual source.

The mouth gag has been employed in a series of 800 tonsillectomies in patients ranging in age from 10 months to 11 years. With oxygen flowing at a rate of 1500 cc. per minute (following removal of adenoids), the reaction time was definitely decreased; it ranged from twelve to twenty minutes, proportional to the operating time. Therefore, the hypoxia which is present during a prolonged reaction time was not encountered. During the immediate postoperative period, with the mouth gag closed and oxygen still being administered, when the first episode of vomiting occurred, the vomitus was easily aspirated.

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To the Editor:

To provide efficient and inexpensive grounding of operating room personnel, the following procedure has been found valuable: An aluminum strip from an intravenous infusion bottle has been bent so that it will touch the sock inside the shoe and then make contact with the floor at the broad part of the heel, as indicated in figure 1. The conductivity is then tested by use of the device described by Hickcox, Tovell and Lovell in Anesthesiology 12: 506 (July) 1951. This device indicated that most leather shoes are not of themselves adequately conductive. Most commercial conducting strips for shoes are expensive, especially when operating room personnel changes rapidly, as in our teaching institution. Most conducting strips discolor stockings. Many of them do not fit an unconventional type of heel. The aluminum strips are satisfactory as shown unless the wearer has an especially thick sock, in which case he can fold the aluminum inside the sock or wet the sock.

Doctor George J. Thomas of Pittsburgh,