NEW, DIRECT-VIEW, SELF-RETAINING LARYNGOSCOPE.

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I beg to submit to the medical profession a new, direct-view, self-retaining laryngoscope.

As seen in Figure 1, the instrument consists of a tongue-blade, a palate-blade, a palate-blade supporter and screws for connecting and manipulating them. The tongue-blade is long and narrow, to reach from the teeth of the lower jaw to the base of the epiglottis, and is fastened at right angles to a handle. The palate-blade, also, is long and narrow and is meant to reach from the hard palate, just back of the teeth, to the cervical vertebrae near the arytenoid cartilages. The ends are suitably shaped to fit the parts. The palate-blade is fastened at its proximal end (C) to the palate-blade supporter. The palate-blade supporter is long and narrow, and its lower end is shaped like a two-pronged fork, with the tines bellying out in the middle to form a space to look through. To the lower ends of the tines (C) is fastened the palate-blade, by hinged joints.

The palate-blade supporter lies flat on the handle of the tongue-blade and by a screw arrangement at A can be made to slide up and down it along its longitudinal axis. Movement of the palate-blade supporter causes the palate-blade to move to or from the tongue-blade. The distal end of the palate-blade can be made to approach or recede from the distal end of the tongue-blade by turning the screw at B, which controls a lever extending from the palate-blade up alongside one of the tines of the fork.

To use this laryngoscope it is necessary to have the patient thoroughly anesthetized, either locally or generally. Use for local anesthesia an equal mixture of 20 per cent cocain and 1-1000 epinephrin. No assistant is needed. After the patient has been anesthetized he is put, face upward, on a table, with his head hanging over its edge. It is best to have the head of the table raised, so that the mouth of the patient is on a level with the physician's eye. This enables the physician to assume a comfortable position and facilitates his work. The laryngoscope is introduced, with the blades together and the handle upright, until the epiglot-

Figure 1.

tis comes into view. The tongue-blade is so manipulated that the epiglottis is caught between the blade and the tongue and is kept out of the field of vision. The arytenoids are then seen and the introduction of the instrument is continued until the proximal end of the palate-blade slips inside the teeth. The relation of the instrument to the anatomy will then be as illustrated in Figure 2.

Figure 2. Diagram showing instrument in position with blades approximated and arytenoids in view.

By turning the upper and lower screws, the blades will be pushed apart, the tongue and epiglottis will be forced into the submaxillary regions and the cords will come into view, as seen in Figure 3. Only enough force should be used in turning the screws to fix the instrument in position with moderate firmness. It can then be left without attention and the physician will have both hands free for his operations.

I have used this instrument on eight cases, six of them in Dr. Emil Mayer's clinic, service of Dr. Yankauer, at the Mount Sinai Hospital Dispensary, and two in Dr. Lapat's service at the New York Polyclinic. In all these cases I obtained a complete view of the larynx.

Figure 3. Diagram showing instrument in position with blades separated and cords in view.

In conclusion, I wish to make my acknowledgments to the above gentlemen and to Dr. McDonald, professor of anatomy in Fordham University Medical College.

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