

mittee for Anesthesia Gas Machine Performance Requirements have asked that we seek out and collate the problems which are being experienced with apparatus throughout the country, as a first step in the evolution of pertinent performance specifications.

To dispel reticence owing to fear of possible legal action, we ask that, though the precise type and make of apparatus used be specified, the names of the people involved and the institution should not be given. All replies will be submitted to both the manufacturer's engineers concerned and the engineers on the subcommittee so that they may

evolve specification for better and safer equipment.

JAMES A. MEYER, M.D., LTC, MC  
Chairman, ASA Committee on Equipment  
Letterman General Hospital  
San Francisco, Calif. 94129

LESLIE RENDELL-BAKER, M.D.  
Vice Chairman, Sectional Committee Z79  
The Mt. Sinai Hospital  
100th St. and Fifth Avenue  
New York, New York 10029  
(Members Z79 Subcommittee on  
Performance of Anesthesia Gas  
Machines)

### Obstetrics and Pediatrics

**STEROIDS IN CROUP** The value of a single large dose of dexamethasone sodium phosphate in children with acute croup was assessed in a controlled double-blind study. The signs of respiratory obstruction subsided more rapidly in the dexamethasone-treated patients, but the average hospital stay was not significantly reduced with dexamethasone. Croup is a symptom complex with multiple etiologies, and it is possible that the cases in the control and experimental groups may not have been comparable in cause or severity. Hence, the results of this study should be interpreted with caution. (James, J. A.: *Dexamethasone in Croup—a Controlled Study, Amcr. J. Dis. Child.* 117: 511 (May) 1969.)

**SURGERY FOR CONGENITAL DEFECTS** The pediatric surgeon must question the value of investing large expenditures of skilled medical nursing time, and monetary expense, to save newborn infants who have severe congenital defects. Physically malformed infants are classified as follows: 1) infants likely to be completely cured by surgery; 2) infants who after treatment will be handicapped to some extent but still may be able to lead relatively normal lives; 3) infants who after treatment will have severe physical handicaps and will have to lead more or less sheltered lives; 4) infants in classes 1 to 2 who, in addition, are of subnormal intelligence but can be trained to a point; 5) infants in classes 1 to 3 who, in addition, will be idiots leading vegetable existences. Theoretically, all but Class 5 are operated upon. In practice, ordinary or obligatory means of preserving life are distinguished from the extraordinary or unobligatory. Ordinary treatment is treatment carried out with a reasonable degree of success and for which satisfactory aftercare exists. In localities where it is clearly impossible to operate on all neonates and to give them satisfactory aftercare, priority should be given to the infants in the highest classification. If the operation is denied, infants should be given all natural means of preserving life (food, diet, etc., good nursery care, and appropriate means to relieve pain). The author prefers not to use antibiotics. Contrary to popular belief, there are not great differences of opinion on these matters among men of different religious denominations. (Rickham, P. P.: *The Ethics of Surgery in Newborn Infants, Clin. Pediat.* 8: 251 (May) 1969.)