

Even movement, such as a response to tail clamping, may not indicate "pain," and therefore may not be an appropriate response for study, as it may represent a pseudoflexive reflex mediated by the spinal cord.³ In addition, Chinese acupuncture-anesthetists concede that acupuncture does not obtund certain reflexes, e.g., traction and cough.⁴ Obviously many of the investigations on acupuncture will have to contend with ancient arguments as to what constitutes pain.^{5,6}

It should also be made clear that surgical acupuncture is not closely related to traditional acupuncture. The former is non-systematic and empiric, whereas the latter is based on a very complex system of medical philosophy whose validity may be questioned but which serves to make a corpus of observations comprehensible.

Ancient acupuncture charts are available for the horse, goat, cow, elephant,⁷ and man, if one wishes to study traditional points. If one wishes to study modern empiric points for surgical analgesia, however, the only suitable subject for study is man in a double-blind protocol; otherwise, one is making stabs in the dark.⁶

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To the Editor:—I found the Letter to the Editor, "The Influence of Acupuncture on Halothane MAC in Dogs" (*ANESTHESIOLOGY*, December 1973), disturbing. The authors placed needles "speculatively" in the extremities of five dogs, not knowing their acupuncture points, and found that these randomly inserted needles did not lower halothane MAC. They leave the impression that perhaps acupuncture does not produce analgesia at all. By comparison, one could state that the effect of a local anesthetic when used to perform a brachial plexus block would not lower MAC if the solution were injected into the belly of the biceps muscle. This could have been an interesting study utilizing either animals with well-established acupuncture points or human volunteers as double-blind study with known acupuncture points and placebo points. But to do acupuncture analgesia without using acupuncture points and then to conclude that acupuncture does not lower MAC is not valid.

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The above letters were referred to authors; the senior authors offer the following reply.

To the Editor:—Drs. Millman and Szele note the complex problems involved in investigating acupuncture. Nevertheless, reports of operations performed with electrical or manual acupuncture suggest the effectiveness of this technique for anesthesia. Confirmation of the anesthetic effect of acupuncture is needed.

We speculated an anesthetic effect related to acupuncture should be reflected in animals as decreased requirements for a concomitantly administered inhalation anesthetic. Since dog acupuncture points have not been described, the acupuncture needle placement in our dog studies was speculative. Even in man, for whom acupuncture points have been described, agreement as to specific acupuncture points for anesthesia does not exist.¹ However, the acupuncture needles were placed

anatomically in the dog to correspond to the acupuncture needle placement used by one of us (KCK) for treatment of coccygodynia and sciatica in man. Electrical or manual acupuncture delivered with these acupuncture needle placements did not decrease the amount of halothane necessary to prevent movement of the dog in response to a tail-clamp stimulus. Since this acupuncture needle placement did not change halothane MAC, placebo acupuncture needle placement did not seem indicated. Finally, we agree double-blind studies are desirable, but this approach was not applicable to the experimental model we utilized.

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Anesthesiologists in Intensive Care

To the Editor:—I read with interest Little's editorial in the November 1973 issue of ANESTHESIOLOGY, dealing with such apparently diverse issues as the "discovery" of anesthesia in Hartford, Connecticut, and the current interest among members of our specialty in the care of critically ill patients. While many of the points he makes are well taken and insightful, I find the criticism of anesthesiologists directing their attentions to intensive care unduly harsh. To imply that such men are "unaffectedly simple and unsophisticated" and attempting "in essence to destroy their own specialty" is inaccurate at best.

As Dr. Little intimated, intensive care units

for critically ill patients grew, in many major medical centers, from respiratory care units. In turn, these had evolved as a logical extension of recovery room and intraoperative anesthetic care. In each transition, the anesthesiologist has not only continued his involvement, but expanded his expertise to include increasing aspects of patient care. Some found that this form of medical practice was exciting and challenging, and chose to devote large proportions of their careers to it. In what sense is this reprehensible? These are highly qualified, dedicated physicians who have acquired training beyond their anesthesia residency to enable them to undertake a specialized form of medical care.