statistical manipulations that they have applied to their data. As Takasaki et al. point out, the very large difference in dose requirements between their series and ours may be explained by the sevenfold difference in spreads of the injections. In their series large dose requirements were associated with a very slow injection rate of 0.15 ml/sec, whereas in our series lower dose requirements were associated with an injection speed of 1 ml/sec. Contrary to their suggestions, we did not find that uneven or unsatisfactory analgesia resulted from rapid injection. Physical spread verified by roentgenography and pharmacologic spread verified by clinical examination showed a uniform and symmetrical distribution. Takasaki et al. question the efficacy of our blocks, and the validity of our data, since our patients were given light nitrous oxide–halothane anesthesia for humanitarian reasons. In fact, our observations of segmental spread were made within 60–90 min of injection, and the upper level of analgesia was stable during that time; any regression in dermatome level would have given a falsely high rather than a falsely low value for dose requirements.

Finally, we are astonished by the hybrid statistical treatment that Takasaki et al. have applied to their data in figure 1, where volume dose requirements are plotted against body weight. All children of less than 8 kg body weight received 1 per cent lidocaine, while all those weighing 8 kg or more received 50 per cent more drug (1.5 per cent lidocaine). They have taken these two disparate groups and treated them as if they were a single homogeneous population. We submit that this is a highly improper and misleading statistical manipulation, and that the convincing-looking correlation coefficient of 0.93 in figure 1 is meaningless.

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Dental Anesthesia

To the Editor:—I was particularly interested in the comments of Dr. McLaughlin and Drs. Klein, Wollman, and Cohen regarding anesthesia in dentistry. In all institutions the anesthesia training afforded a dental resident in anesthesiology is parallel to that given to a medical resident in anesthesiology. Didactic and clinical training has been updated so that most anesthesiology training programs for dentists are now a minimum of one year, or more often two years. The full-time dental resident in anesthesiology

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