

removed, place the 3-ml plastic syringe, without disturbing the position of the piston, alongside the catheter. Slowly withdraw the catheter until the third mark on the catheter coincides with the front black ring on the piston. Exactly 2 cm of catheter are in the epidural space.

In patients who are obese, restless, or having edematous backs, one may choose to leave an extra 1 cm of catheter in the epidural space. The catheter is fixed in the routine secure fashion.

We are using this procedure in clinical practice and are impressed with excellent results.

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ASA PS Classification Is Not Risk Classification

To the Editor:—We agree with Dr. Bayes¹ conclusion that asymptomatic cigarette smokers should be classified at least as an ASA PS Class II and that smokers have a systemic disease. They may indeed have pulmonary and vascular abnormalities. Bayes, however, made the not infrequent error of referring to this system of ASA PS classification as a “risk classification.” This classification has survived less accurate references. In their comprehensive study of perioperative mortality, Beecher and Todd² incorrectly equated physical status with perioperative risk. Feinberg³ erred in the same manner in titling his article on obesity. Goldman *et al.*⁴ erroneously referred to the ASA PS classification as the “Dripps—American Surgical Association (sic),” and mistakenly described it as a “preoperative assessment of surgical risk.”

The ASA PS classification was devised by Drs. Saklad, Rovenstine, and Taylor more than 40 years ago.⁵ They originally were given the task of defining a classification of “operative risk.” They wisely concluded that operative risk was influenced by too many intangibles and they settled on a system of *physical status* classification alone. Throughout these past four decades the system has endured several minor changes and its spirit remains intact. In the words of the originators, “No attempt should be made to prognosticate the effect of a surgical procedure upon a patient of a given Physical State . . . it may be difficult, at first, for the anesthetist to classify patients with reference to their physical state alone. Subconsciously, he is apt to allow his knowledge of the contemplated surgical procedure to influence him in his grading of patients.”

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The concept of risk involves danger and the ability to predict outcome. One facet of this is a uniform classification system or a system of taxonomy which makes for consistency regardless of who utilizes it. Since we lack accuracy and therefore this element of consistency in predicting morbidity and mortality, it is far more logical to be precise with a description of physical state. This, after all, has been demonstrated to correlate positively with outcome.⁶

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