made. The plastic bag is placed on the table beneath the patient (and the draw sheet) and the patient is returned to the supine position. Transfer to a stretcher or bed of similar height is effected by pulling on the draw sheet. The head and lower legs must be supported during transfer but the larger part of the patient's mass slides without being lifted. An assistant should hold and maintain tension on the trailing end of the draw sheet to prevent a fall in the event of separation of table and stretcher. The method is less cumbersome and less uncomfortable for the patient than roller/conveyor devices and is much preferable to a multi-person lift (especially for transfer to a wide bed). "One, two, three, heave" becomes "one, two, three, and a slow slide." The latter is safer for all concerned. The patient's weight is never "airborne;" the slide can be interrupted easily to unhook the inadvertently snagged iv or urinary catheter; and the popping of facet joints and nuclei pulposi and the choruses of "Oooh, my back!" rarely are heard.

This technique may well be in wide use already, but the authors have not encountered it previously. We would be pleased to give credit to the originator but he/she is unknown to us. The "Man from Glad," perhaps?

JOHN C. DRUMMOND, M.D.
Assistant Clinical Professor of Anesthesia
University Hospital, University of California, San Diego

HILDA SAGER, R.N.
Staff Nurse, ICU, The Green Hospital of Scripps Clinical, La Jolla, California

(Accepted for publication June 14, 1982.)

Anesthesiology
57:550, 1982

Duplication and Fragmentation in Publications

To the Editor:—ANESTHESIOLOGY recently published an important study on the effects of epidural morphine by Bromage *et al.*[1] To my great surprise, I find the same study by the same authors published the same month in *Anesthesia and Analgesia*.[2] The "Materials and Methods" and "Results" sections are nearly identical in the two papers (they should be as it is the same study). Different aspects are stressed in the two discussions. As the titles indicate, rostral spread of the epidural morphine is discussed in more detail in ANESTHESIOLOGY, the non-respiratory side effects in *Anesthesia and Analgesia*. Lengthening of the discussion by one page in one paper should make the other paper unnecessary.

The authors even 1) refer to the ANESTHESIOLOGY paper in the *Anesthesia and Analgesia* paper, and 2) indicate that the respiratory side effects from the study are going to be published in a third (!)paper. The latter suggests unnecessary fragmentation of information, while the first two articles are not even that. Publishing the same morphine concentrations in a table in one journal and as a figure in the other does not make them different studies.

How can the authors defend the submission of the first two papers with the signed statement (which I assume they sent to both journals) declaring that the manuscript has not been submitted for publication in whole or in part elsewhere. Even a brief look at the two abstracts would cause one to question this. Is the need for a long publication list so important as to warrant such duplication (and fragmentation to follow) of otherwise good scientific material?

Following the precedent established by these authors I submit this letter to the editors of both journals.

PETTER ANDREAS STEEN, M.D.
Department of Anesthesiology
Ulleval Hospital, Oslo, Norway

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1. Bromage PR, Camporesi EM, Durant PAC, Nielson CH: Rostral spread of epidural morphine. ANESTHESIOLOGY 56:431–436, 1982
2. Bromage PR, Camporesi EM, Durant PAC, Nielson CH: Non-respiratory side effects of epidural morphine. Anesth Analg (Cleve) 61:490–495, 1982

(Accepted for publication July 29, 1982.)

Anesthesiology
57:550–551, 1982

In reply:—We are grateful for the opportunity to repudiate Dr. Steen's allegations of deliberate duplication and fractionation of data. We agree with Dr. Steen that unnecessary fractionation and duplication of data is reprehensible. We also agree that our two recent papers to which he refers, in common with many others pub-

lished today, could be compacted to almost abstract proportions, and still transmit a few cryptic messages. But we disagree most strongly with Dr. Steen's view that our material could or should have been presented in a single paper, for the following reasons.

First, our volunteer study set out to ask three questions: 1) Do effective analgesic doses of epidural morphine bestow a limited segmental block as originally believed, and if so for how long? 2) Are the analgesic side effects of intravenous morphine different from those of epidural morphine, and if so how long does each last? 3) How can the side effects be treated, and can we establish a working hypothesis for their causes? The first and second questions were answered, and the third partially answered, at least insofar as it cleared up some existing misconceptions in the literature. In our view, the mass of new data generated from 500 hours of observation and measurement could not be reduced and contained in a single paper, without losing much of its force and argument. The data fell naturally into two distinct parts, with rostral spread as one, and the side effects as another. There was indeed some overlap in the two papers, but this seemed a necessary price to pay for clarity of the overall picture. Unfortunately our respiratory data was not fully reduced (and is still not fully processed), and the reviewer of our second paper requested that this incomplete respiratory data be either expanded or deleted. We felt the latter course was more prudent in view of the difficulties that we were experiencing in agreeing upon the correct statistical treatment of the respiratory material. Thus, the paper on side effects lost some of its more important content and the final version was less complete than we had intended.

Our second reason for full reporting and discussion was the strategic nature of the study. A literature review had failed to unearth any continuous study on the analgesic and side effects of morphine over periods of more than 6 to 8 hours. Our protracted protocol of 24- to 26-hour sessions was therefore unique both in duration, and in the quantity and diversity of the information it yielded. Moreover, the new information had both clinical and conceptual immediacy that required early and complete treatment for reasons of safety and good practice.

We trust that these observations will give Dr. Steen some insight into the events and intents that led to the publication of two papers instead of a single truncated and incomplete version of the total picture.

PHILIP R. BROMAGE, M.B., F.F.A.R.C.S.
Department of Anesthesiology
University of Colorado
Health Sciences Center
4200 East Ninth Avenue
Denver, Colorado 80262

(Accepted for publication July 29, 1982.)

Anesthesiology
57:551, 1982

(*Editorial Comments*)

The interested reader is encouraged to compare the two Bromage *et al.* articles before arriving at a judgment.

THE EDITOR

Anesthesiology
57:551–552, 1982

Respiratory Assistance Secured by Jet-Ventilation during Broncho-Fiberscopy in Forty-nine Infants

To the Editor:—Bronchofiberscopic examinations remain hazardous in infants with respiratory distress. To prevent dramatic impairment of gas exchange, we developed a method of respiratory assistance using jet-ventilation which has been used in 49 infants of three days to three years of age. Similar to the study of Satyanara *et al.*,[1] the injector was connected directly to the suction-channel of the fiberscope, which served as the jet-channel. Ventilation variables were regulated preoperatively by measuring delivered oxygen pressure and volume at the tip of the bronchoscope. Insufflation time was limited to 0.3–0.5 s with an inspiratory to expiratory ratio