

problem, it would look better in court to tell the jury that oxygen concentrations were being measured. But what additional information would these analyzers provide? If the practitioner sets the gas flows correctly, then the oxygen analyzer might detect some machine malfunctions. But machine malfunctions occur less frequently than human errors. Would the practitioner who forgets to turn on sufficient oxygen remember to turn on the oxygen analyzer?

There may be better ways to assure that minimum safe concentrations of oxygen are delivered to patients. Proportional flow devices are currently available which mechanically link the oxygen and the nitrous oxide flow meters, preventing oxygen concentrations of less than 30%. Should these devices become standard equipment? Making oxygen analyzers integral parts of anesthesia machines offers advantages over that of add-on devices. Should we discard our old anesthesia machines in favor of new integrated equipment which contains gas analyzers for oxygen, carbon dioxide, nitrous oxide, halothane, etc.?

If we are required to add oxygen analyzers to our anesthesia machines, then we need a different kind of

analyzer than is presently being sold. Simply stated, we need an oxygen analyzer without an OFF switch. We need one which is continually ON and sounds an alarm whenever the oxygen concentration drops below 21%. The device should have warnings to alert the user that the battery needs to be changed or that the sensor needs maintenance. Automatic calibration against room air is also highly desirable.

Perhaps investigators who study anesthesia mishaps can provide us with more recommendations and specifications for oxygen analyzers. However, until a consensus is reached, practitioners will have to decide for themselves what is adequate monitoring for general anesthesia and which new instruments will produce incremental improvements in anesthesia safety. We certainly cannot rely on the sensational advice from a TV show.

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Gerontologic Pharmacology Studies Urged by the National Institute on Aging

To the Editor:—We would like to bring to the attention of the scientific research community the report of a workshop on gerontologic pharmacology which was published recently* and of a National Institute on Aging Pharmacology Program announcement† based on its recommendations. It has been widely reported that elderly people suffer a greater incidence of adverse drug side effects and of drug/drug interactions than do young adults. Evidence has been reported of altered patterns in the elderly of drug distribution and responsiveness. Since drugs generally are tested in young

adults and dosage adjusted to their needs, it is not surprising that elderly people may respond differently. Much research is needed to determine where age-related alterations in drug responses exist and when found, to determine their cause(s). Studies are encouraged in both clinical and basic research areas. The addition of cohorts of elderly to ongoing studies may be an appropriate means for detecting significant differences and special NIA programs are available for the performance of pilot studies.

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* Steinberg GM, Schneider EL: The National Institute on Aging's Second Workshop on Pharmacology and Aging, June 4-5, 1981. *The Pharmacologist* 24:65-67, 1982.

† Pharmacology Program, NIA. NIH Guide for Grants and Contracts 11: No. 5, 42-44, April 23, 1982.

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Editorials Should Elucidate not Obfuscate II

To the Editor:—Dr. Colin Blogg is not being too stuffy or unkind in seeking greater clarity of prose and

thought in medical writing.¹ ANESTHESIOLOGY is far from being the worst culprit; but "caregiving environ-