

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.<sup>1</sup> ANESTHESIOLOGY is far from being the worst culprit; but "caregiving environ-

ment," "auditory orienting response," "active interactions," "to adequately conceptualize"—daunting phrases plucked at random from an opaque editorial by Dr. E. Tronick, a psychologist, in the May 1982 issue<sup>2</sup>—are hard to defend. They are not English: they are gobbledegook. Comprehensible to a fellow psychologist, perhaps, but then, Dr. Tronick is not writing for psychologists.

On the other hand, those who care for the language should not be pedantic. We have no right to demand perfection, if only because it is not given to us all to recognize perfection when we see it. Nor is a medical journal the place for flights of literary fancy; jargon is sometimes inescapable. Provided an editorial is clear and concise—which is all one can ask—the author is free to use English English, American English, or even pidgin English. He is not at liberty to perpetrate *diseased* English.<sup>3</sup>

In the interests of clarity and readability, if for no

other reason, the Editor owes it to himself and to his journal to protect the language, or at least to prune the worst excesses. There could be no more unenviable or time-consuming task; but if he does not do it, no one will.

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2. Tronick E: A critique of the neonatal neurologic and adaptive capacity score (NACS). *ANESTHESIOLOGY* 56:338-339, 1982
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#### *(Editorial Comments)*

Current policy permits *both* the author's opinion and style to dominate the Editorial and Correspondence sections of the Journal (within limits). An ample supply of "proper" (that is, austere and sterile) writing style can

be found in the remaining sections. Gobbledegook, like beauty, is often in the eye of the beholder.

THE EDITOR

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### Selective Endobronchial Blocking vs. Selective Intubation

*To the Editor:*—Watson *et al.*<sup>1</sup> have reported an original method for selective intubation in a female infant with right lung sequestration. The procedure appears to be safe and suitable for a most difficult problem in surgical practice: pulmonary resection in children and infants.

Although several difficulties can occur with their use, double-lumen tubes have gained acceptance in adults since Carlens's report.<sup>2</sup> However, these tubes are not available for small patients, and, in 1969, Vale described<sup>3</sup> a procedure for lung exclusion using a Fogarty catheter as an endobronchial blocker. Thus, separate-lung ventilation was replaced by one-lung ventilation. Despite several reports<sup>4-6</sup> of its satisfactory use, this procedure has not become routine practice because of technical difficulties inserting the catheter into the appropriate bronchus.

Employment of flexible bronchoscopes is a sure way to accomplish selective positioning of tracheal tubes,

like in the case of Watson. It also allows precise introduction of a balloon-tipped catheter (Swan-Ganz catheter). We have employed this procedure in seven children, including two infants younger than 18 months. After insertion into the trachea under visual control, the tip of the catheter is introduced into the diseased pulmonary lobe. The balloon is inflated with subsequent selective lobar exclusion. An X-ray of the chest can be obtained, but we have not found it necessary.

At this time, a tube is inserted into the trachea and ventilation is carried out as usual. This procedure prevents either gas issuing from ruptured bronchioles or the reflux of blood and pus. It provides the same advantages as does selective intubation, plus one additional benefit: bilateral pulmonary ventilation, which considerably reduces intrapulmonary shunting. Moreover, the excluded pulmonary tissue continuously remains under the anesthesiologist's control: the lumen of the catheter can be used to reexpand the lobe to facilitate surgical