Missing Documentation

To the Editor—I read with interest Dr. Koop's editorial regarding environmental tobacco smoke (ETS). It was surprising to find within it references to "6,000 American teenagers try their first cigarette each day," "Smokers tend to underestimate the number of cigarettes smoked per day," and "the accepted and conservative number of nonsmokers who die each year from ETS exposure is more than 50,000," without any citation of a scientific source for these statements. These important statements are striking and, if true, tragic. Yet, without proper documentation, their validity cannot be assessed.

Most health-care workers probably share Dr. Koop's view that any smoking is too much. And when we hear lay press reports of a large European study of environmental tobacco smoke in which no excess morbidity or mortality was found, we long for documentation to challenge that conclusion.

It is important that statements made in scientific publications be based on solid evidence and that the evidence be made accessible. It would be very helpful if Dr. Koop would provide appropriate references for these statements, and I ask that the editor make a greater effort to ensure that such references are included in the future.

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Reference

1. Koop CE. Adverse anesthesia events in children exposed to environmental tobacco smoke. Anesthesiology 1998; 88:1141–2

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Cost-efficient Carbon Dioxide Monitoring via Nasal Cannula

To the Editor—It is routine to monitor end-tidal carbon dioxide concentration during anesthesia, whenever possible. During sedation using spontaneous respiration via native airways, carbon dioxide monitoring allows for verification of air exchange and respiratory rate, excluding mere motion against an obstructed airway. Nasal cannulae increase ambient oxygen concentrations, and coupled with blunt metal 18-gauge cannulae (Lifeshield-Abbott list #11302; Abbott, Abbott Park, IL), provide inexpensive carbon dioxide detection in the expired

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Jetting Lidocaine through the Atomizer

To the Editor—Using the atomizer to deliver local anesthesia to the larynx is common, and one common variation is to deliver high-flow oxygen through the atomizer. We have tried something different, by connecting a jet ventilator hose to the atomizer and setting the jet pressure at 5–10 psi. The atomizer mist thus produced is forceful and can be adjusted by altering the pressure of the jet. The length of the jet tube should be adequate to reach patients who are bedridden, and who have restricted mobility because of an unstable cervical spine and traction. We have used this technique several times; it works, and it seems to be a reasonable alternative method for using the atomizer to deliver topical anesthesia to the larynx.

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