side. He was then log-rolled onto his back. There were no significant hemodynamic changes as a dense sensorimotor block to a T4 level developed. The gastrostomy began 5 min later and was followed by the inguinal hernia repairs. There were no episodes of inadequate anesthesia, desaturation, apnea, or hemodynamic instability. The child received normal intravenous hydration through a preexisting intravenous catheter. No sedatives were required. He was returned to the pediatric intermediate care unit. His residual block began to recede approximately 2.5 h after block, and by 4 h after block, he exhibited baseline sensorimotor function.

We chose a spinal anesthetic after considering risks and benefits. In reviewing the current literature, much attention has been focused on considering peripheral lower extremity and lower abdominal surgeries as appropriate for subarachnoid blockade in pulmonary compromised infants. Specific reference to upper abdominal surgery, particularly as regards pulmonary function intraparatively and postoperatively, is lacking. Rice et al. have researched the effect of subarachnoid block in high-risk infants undergoing lower abdominal surgery and suggest that, although breathing mechanics are altered, there are no significant changes in transcutaneous carbon dioxide or arterial oxygen saturation with sensorineural block to T4 levels. *Given this child's history of difficulty in separation from mechanical ventilation, we elected to attempt subarachnoid block and proceed to tracheal intubation and a combined general and regional anesthetic if required.

Our case suggests that subarachnoid block may be an acceptable anesthetic for relatively simple upper abdominal surgery, allowing many of the same benefits portended for lower abdominal and peripheral lower extremity surgery.

Brian K. Gingrich, M.D.
Director, Pediatric Anesthesiology
Nassau County Medical Center
2201 Hempstead Turnpike
East Meadow, New York 11554

Reference


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Anesthesiologists and Substance Abuse

To the Editor:—While Schmidt and Schlesinger are to be commended for their attempts to bring greater accountability to the distribution of controlled substances at their hospital,1 they are to be loudly condemned for their statement, "Substance abuse is more common among anesthesiologists than among any other medical specialty," citing Spiegelman et al.’s 1984 paper.2 What this source states is that anesthesiologists are over-represented in substance abuse treatment programs, but it is a vast leap of science and fact to say this equates to higher rates of abuse among anesthesiologists than any other medical field. What it may mean is that anesthesiologists are more likely to recognize a problem in themselves and self-refer to those treatment programs.

Among the many things we as anesthesiologists must be vigilant of is the transmutation of rumor and innuendo into fact. If we are not, then we can expect those less expert than ourselves to worry needlessly about their anesthesiologist citing our own journal as the source of those fears.

George M. Woods, M.D.
1835 Vallejo Street, Apt. #304
San Francisco, California 94123

References


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In Reply:—Our reference to Spiegelman et al.’s1 paper was not a "transmutation of rumor and innuendo into fact." Several anesthesiology textbooks review this and other literature and reach the same conclusion. Berry and Katz2 state, "There are more addictive diseases among anesthesiologists than among any other medical specialty." According to Arnold,3 "The disease is more common in some spe-