FIG. 1. Modifications by diphenhydramine and cimetidine, singly or in combination, of decrease in mean blood pressure induced by dTc injection. Each point represents the mean blood pressure. Data were analyzed using one-way analysis of variance and Newman-Keuls multiple range test. D = diphenhydramine; C = cimetidine. Asterisk indicates that the values obtained following treatment with diphenhydramine alone or in combination with cimetidine were significantly greater than those of control or with cimetidine alone (P < 0.05). Figures in parentheses indicate the number of patients studied.

informed consent was obtained from each patient by the chairman of the Department of Anesthesiology, Professor Kenjiro Mori. The patients were divided into four groups of six patients each. All patients were premedicated with 0.5 mg im atropine. Direct blood pressure was recorded through a cannulated radial artery. Anesthesia was induced with fentanyl (3 μg/kg), thiopental (6 mg/kg), and N₂O/O₂ (1:1), and ventilation was assisted using a face mask to maintain end-tidal CO₂ at approximately 30 mmHg throughout the study. Five minutes after thiopental administration, diphenhydramine (1 mg/kg) and cimetidine (4 mg/kg) were given, singly or in combination in three groups; the control group received no antagonist. One minute after the administration of the histamine antagonists, dTc at a dose of 0.6 mg/kg was given as a bolus injection.

Results are shown in figure 1. In the control group, the administration of dTc produced a rapid decrease in blood pressure, reaching the maximum decrease within 2 min. Thereafter, the blood pressure gradually returned to the preadministration level. The decrease in blood pressure 2 min following dTc injection was significantly attenuated by treatment with diphenhydramine alone or in combination with cimetidine but not with cimetidine alone.

Our findings indicate that treatment with H1 antagonist alone is sufficient to prevent the hypotension induced by the bolus injection of dTc. This is in contrast to the response observed with infusion of morphine.

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Unexpected Wedge Pressure (at less than 35 cm) May Be Artifactual

To the Editor— I read with interest the letter by Badenhorst concerning proximal port dysfunction in pulmonary artery catheters inserted from the right subclavian vein. In several patients wedge position was obtained at a catheter insertion distance of less than 35 cm. This interfered with use of the proximal infusion port and therefore cardiac output determinations. The patients are all described as adult females of “average build.” In our intensive care unit we have encountered a similar problem but with a different interpretation. In several cases catheters advanced from a right subclavian position would develop a dampened wave form with the appearance of a wedged tracing, at an insertion length of 30–40 cm. We frequently use fluoroscopy for catheter placement and could see that this tracing corresponded with advancement of the catheter tip into the apex of the right ventricle. It should be noted that the natural curvature of the catheter itself has a tendency to direct the tip into this
position when advanced from the right subclavian or right antecubital approach. Correct positioning of the catheter in our adult female patients resulted in wedge positions at an average length of 55 cm with no cases at under 45 cm. Could this have been the cause of the problems encountered by Badenhorst? A portable chest x-ray could be used to confirm questionable catheter positions. Alternatively, a blood gas taken in the “wedge position” might be helpful to differentiate positions. A higher oxygen saturation would be expected in the pulmonary artery wedge position as opposed to the right ventricular location, although this is not absolutely reliable.2

If indeed pulmonary wedge position is being reached at less than 55 cm in some patients, then perhaps thought should be given to use of the pediatric 5-French (model 93A-132-5F, Edwards Laboratories) or adult 6-French (model 93A-096-6F) pulmonary catheter. Each of these have a proximal port only 15 cm from the tip and are designed for such situations.

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Correctly Identifying the Sexes: Use and Abuse of the Word Man

To the Editor:—Recently an article appeared in Anesthesiology that contained the following advice on how to attract and retain good faculty1:

“Be sure that the young man has outstanding clinical skills. . . .”
“Give young men their head.”
“Invest . . . in more young men.”
“Only enthusiastic and happy faculty recruit the next generation of bright young men.”

This is not the accepted English usage of man to refer to both sexes, but the identification of appropriate faculty candidates as specifically and exclusively male. It is exactly like the odious recruitment letters that used to read “We are looking for a man who. . . .”

It is unfortunate that someone can still express himself in these terms in 1985. It is even more unfortunate that Anesthesiology should appear to place a seal of approval on this message by accepting it for publication. I hope it was an oversight. Such language surely would not be accepted in the Positions Available section of the classified advertisements; it has even less place in the body of the journal.

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Editorial Comment

It was not really an “oversight”; rather it was simply unseen. Educated during a time of insensitivity to this issue, I still think of the word man as it is first defined in one of my dictionaries: “A human being; a person, whether male or female” (Webster’s New Twentieth Century; second edition). I have reason to believe that the same can be said for the author. In any case, Doctor Kendig’s letter will serve to sensitize me; any recurrences (gods and goddesses forbid) will truly be an oversight.