18-ga needle. When bronchodilator is required, the elbow connector is placed in its standard position in the breathing circuit, and the Medi-Haler® is depressed once or twice; the patient then is given a large positive-pressure breath. The modified elbow connector then is removed from the circuit until the next dose of bronchodilator is desired.

No special adaptor is required, and the system can be set up quickly, thus making use of inhaled beta-adrenergic agents an attractive alternative for the treatment of intraoperative bronchospasm.

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Another Method to Provide Left Uterine Displacement

To The Editor.—Several inflatable devices to provide left uterine displacement (LUD) have been described. One company makes a device that connects to the common gas outlet of the anesthesia machine* and sells for $275.00. Redick1 has described using an inflatable bag to which rubber tubing and a sphygmomanometer bulb are attached. Placing the bladder from a large blood pressure cuff under the hip also has provided an acceptable degree of LUD.2

We describe a device that can be assembled entirely of discarded materials (fig. 1). An empty 3-l polyvinylchloride bag (previously the container for urologic or arthroscopic irrigation fluids) is connected to a regular iv fluid administration set. A three-way stopcock is attached to the tubing. The barrel of a 3-ml syringe, with plunger removed, connects to the second female port of the stopcock. A 15-mm adapter from a 7-mm endotracheal tube is inserted into the barrel of the syringe. A catheter adapter† may be connected to the male port of the stopcock and a short piece of rubber tubing with a sphygmomanometer bulb attached so the device can be inflated manually. When assembling this apparatus, the spike point of the iv set is cut off to prevent puncturing the bag, and all the connections are


FIG. 1.
glued securely with polyvinylchloride (PVC) cement (the type used on plastic pipe).

To use the device, one merely disconnects the common gas flow hose from the anesthesia machine and connects the 15-mm adapter. The stopcock is turned to direct flow into the bag and a flow of gas, not to exceed 10 lpm, is started. Once adequate LUD is achieved, the stopcock is turned off and the device is disconnected from the anesthesia machine. The common gas flow hose is reattached, and the anesthesia circuit is checked to ensure there are no leaks. Upon delivery of the baby, the stopcock is opened and the patient soon will return to a level position.

This apparatus 1) is free, since it is constructed entirely of discarded elements; 2) takes less than 30 s to inflate, thereby providing rapid LUD; 3) is easy to use; 4) can be left on the bed or delivery table ready for instant use; 5) obviates the necessity of rolling the patient up in order to place a wedge; 6) eliminates the need to reach under the drapes to remove the wedge; and 7) also can be inflated by using an appropriately modified sphygmomanometer bulb. We have used this device on patients weighing up to 115 kg and have experienced no leaks or failures. It is especially convenient because one does not need to leave the head of the table to achieve LUD.

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Does ANESTHESIOLOGY Publish Too Little Clinical Material?

To the Editor:—In his 1983 Ravenstine Lecture on cardiovascular anesthesia, Dr. Keats made a brief analysis of citations to and by ANESTHESIOLOGY. In his conclusions he noted that we do a great deal of talking to each other, as only 48% of all citations to articles in ANESTHESIOLOGY are by nonanesthesia journals. He also noted that, at least in the realm of cardiovascular anesthesia and surgery, we as anesthesiologists have been more responsive than innovative. This was supported by Keats’ finding that from 1978 to 1982 anesthesia journals cited cardiovascular surgical journals twice as often as the other way around.

We believe that one of the major reasons we don’t “talk” to medicine at large is the unfavorable ratio of clinical to experimental articles in anesthesia journals. We feel that clinical work is the strongest link between medical fields and specialties.

We analyzed four of the anesthesia journals mentioned in Keats’ lecture, i.e., ANESTHESIOLOGY (A), British Journal of Anaesthesia (BJA), Anesthesia and Analgesia (AA), and Der Anaesthesist (DA) between 1972 and 1982, and encompassing a variety of criteria. When we measured clinical articles as a percentage of total articles published, A had 45%, AA 56%, and the other two had percentages in between. Approached another way, the percentage of experimental articles was 25 in A, 19 in BJA, 16 in AA, and 12 in DA. It would be interesting to know if clinical anesthesia articles are cited by nonanesthesia journals more frequently than experimental articles. We suspect that this is the case.

We wholeheartedly agree with Dr. Keats and the late Dr. Myron Laver that anesthesia is at its best when its clinical content contributes benefits to medicine at large.

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