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—-are hard to defend. They are not English; they are gobbledygook. 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.3

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.

PETER V. SCOTT, M.B., F.F.A.R.C.S.
Department of Anaesthetics
Bromsgrove General Hospital
Bromsgrove, Worcestershire B61 OBB
England

REFERENCES

(ACCEPTED FOR PUBLICATION FEBRUARY 22, 1982)

(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. Gobbledygook, like beauty, is often in the eye of the beholder.

The Editor

SELECTIVE ENDOBRONCHIAL BLOCKING VS. SELECTIVE INTUBATION

To the Editor—Watson et al.1 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.2 However, these tubes are not available for small patients, and, in 1969, Vale described3 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 reports4–6 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
dissection and placement of sutures; it also allows pus and blood to be suctioned without risk of contamination of the remaining pulmonary tissue.

This procedure is an improvement over previously reported methods for endobronchial blocking and can be an alternate solution to selective intubation as reported by Watson et al.1

BERNARD DALENS, M.D.  
Assistant Professor  
Department of Anesthesiology

ANDRÉ LABBÉ, M.D.  
Assistant Professor  
Department of Pediatrics

JEAN-PIERRE HABERER, M.D.  
Associate Professor  
Department of Anesthesiology

Anesthesiology  
57:556, 1982

New Pediatric Laryngoscope

To the Editor:—In the April 1982 issue of Anesthesiology, Dr. Moynihan recommended to use a thin strip of standard cloth adhesive tape to the lingual surface of the blade to control the slippery tongue of the neonate.1

To overcome this problem, we have developed a new pediatric laryngoscope with a thin and wide blade for easy control of the slippery tongue (fig. 1). In addition, the blade makes an obtuse angle with the handle for facile oral insertion of the blade. This laryngoscope has been on the market for 5 years, and can be purchased from Acoma, Co., Ltd., Japan.

AKIYOSHI MEYUKI, M.D.  
Associate Professor  
Department of Anesthesiology  
University of Hirosaki  
Hirosaki, Japan

REFERENCES

(Accepted for publication June 25, 1982)

Fig. 1. A new pediatric laryngoscope to control a slippery tongue.