frequency of this particular cause of breathing circuit obstruction, any arguments for or against use of these selector valves must remain purely subjective. Nevertheless, we would caution against implementing the specific solution recommended by Drs. Sears and Bocar.

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Anesthesiology
48:300, 1978

To the Editor:—Sears and Bocar describe a serious complication associated with the use of a ventilator.1 However, the anesthesiologist using the ventilator was at fault. Had the anesthesiologist checked the system before using it, the hose leading from the bellows selector valve would have been found to be on the wrong outlet and placed correctly. The suggested modification of the ventilator would have prevented the problem, but so would a more careful application of fundamental anesthetic procedures.

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In reply:—The modification of the selector valve proposed by us provided a simple and expedient solution to a disturbing problem, since the connecting hose does not adapt easily to the bellows outlet without the selector valve. Dr. Cooper correctly notes that with the bag/ventilator selector in the vertical position the breathing circuit would be open to the atmosphere and the ventilator obstructed. In our experience this situation has been readily recognized by failure of the bellows to rise and through the routine inspection and auscultation of the chest after the patient has been connected to the ventilator. Also, in our experience, important leaks in the system are detected early through the routine assessment of patient ventilation immediately after the initiation of mechanical ventilation. I agree with Dr. Cooper’s suggestion that the selector valve should be eliminated, since the potential problems appear to outweigh its one advantage. Perhaps our deliberations will lead to its demise.

Without question, human error in the use of the equipment was the primary factor in the accident described. However, the increasing use of instrumentation in anesthesia multiplies the opportunities for such errors, and this knowledge would appear to provide adequate justification for our attempts to lessen that potential.

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Sedation vs. Relief of Anxiety

To the Editor:—Forrest et al.,1 in their work on the subjective effects of premedication, have touched on a most interesting subject. The essence of their article is the inability of a number of intramuscularly administered premedicants to improve the ease of induction of general anesthesia and to allay apprehension. The authors make the correct distinction between sedation and relief of anxiety, which are
two completely different entities. Sedation is an observed variable, while relief of anxiety is a subjective response by the patient. Too many clinicians equate these two and assume sedated patients to be relaxed and not apprehensive. Drugs such as droperidol have been shown to cause sedation without markedly relieving anxiety. Some of the benzodiazepine drugs, especially lorazepam in lower doses, can relieve anxiety without producing marked sedation. If sedation is the desired end-point, a question arises as to whom is being treated, the doctor or the patient? Too few of us ask the patients what they want from a premedicant and how they feel after they receive their medication.

The results of Forrest et al. are not surprising for several reasons, most of which are mentioned in their discussion. Diazepam was the only tranquilizer studied, and its poor intramuscular uptake compared with intravenous and oral routes is well documented. None of the other medications studied is particularly anxiolytic even when given intravenously.

Our group has been interested in premedication for the past several years. We have studied nearly 3,000 patients using premedicants alone and in various combinations. We use almost exclusively the intravenous route of drug administration given by a physician in a preoperative holding room. Unlike Forrest's work, our studies indicate that many premedicants can relieve anxiety. The benzodiazepine drugs, particularly diazepam and lorazepam, have high patient acceptance, primarily because they relieve anxiety and frequently produce amnesia. Our use of the intravenous route allows for fast onset and high blood levels compared with the intramuscular route. Narcotics, especially morphine and meperidine, are not favored by patients because of their unpleasant side effects and lack of relief from anxiety. We do believe that preoperative anxiety can, in most cases, be treated pharmacologically.

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References

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