

vogue is “fluffy,” understood by patients and better accepted by the “weight challenged.”

The steady increase of obesity during the past three decades has undoubtedly blunted our recognition of its consequences. So much so that I believe many young anesthesiologists don't realize how profoundly the obesity epidemic has changed anesthetic practices. They seem to view heavy patients, reinforced equipment, and XL scrubs as normal—even associating adulthood with bariatric surgery, as I once did childhood with tonsillectomy.

This situation may be changing though. It happened previously with cigarette smoking, which was the scourge of anesthesia when I trained. Smokers emerged from anesthesia coughing and bucking, sometimes cyanotic. Some department members smoked and resisted change. When the Surgeon General declared smoking a health hazard, we talked, innovated, gave up our own cigarettes, and learned to counsel patients. Now, no one in the department smokes. Anesthesiologists comfortably prescribe nicotine patches and refer patients to smoking cessation clinics.

Similar incipient stages for tackling obesity seem to be occurring, with government pronouncements, personal recognition, and cautious conversations under way. The pervasiveness of obesity is uniting patients and caregivers, empowering new conversations. The message, of course, is still in development—with drafts ranging from sympathetic and accepting to scolding and assertive. Since anesthesiologists are intelligent, evidence-driven, and adaptive, solutions should follow. Perhaps then, smoking *and* obesity will become minor problems, and we'll put something besides big equipment in our supersized suites. A fruit bowl and an exercise bike in the break room would be great.

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American Society of Anesthesiologists P5: “With or without” Definition?

To the Editor:

The ASA (American Society of Anesthesiologists) Physical Status Classification System is the most widely used system globally to describe a patient's preoperative medical condition. The first four categories (P1–P4) in the classification have changed little since they were first proposed in 1941,¹ and are familiar to all anesthesiologists.

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† American Society of Anesthesiologists. ASA Physical Status Classification System. Available at: <http://www.asahq.org/clinical/physicalstatus.htm>. Accessed November 24, 2010.

However, the fifth category, P5, as a description of a moribund patient, was first introduced in 1961² and adopted by the ASA in 1963.³ Initially P5 was defined as “a moribund patient who is not expected to survive for 24 h *with or without* operation [emphasis added].”^{3,4} However, this definition was changed during the 1980s (Karen Bieterman, M.L.I.S., Librarian, American Society of Anesthesiologists, Wood Library-Museum of Anesthesiology, Park Ridge, IL, written communication) to “a moribund patient who is not expected to survive *without* the operation [emphasis added].”†

This change was not merely minor nor semantic, however, as the earlier definition implied that the P5 patients would be unlikely to survive 24 h irrespective of operative intervention, while the later (current) definition suggests that survival is possible—but only with operative intervention. Moreover, the current definition has no time period specified. In other words, these two definitions describe two different types of patients.

Unfortunately, this change appears to have been missed by many researchers and authors. For example, in the 7th edition of *Anesthesia*,⁵ P5 is defined as “a moribund patient who is equally likely to die in the next 24 h *with or without* surgery [emphasis added].” Similarly, in the 6th edition of *Clinical Anesthesia*,⁶ P5 is defined as “moribund patient who has little chance of survival, but is submitted to surgery as a last resort (resuscitative effort).” Several recent journal articles have also incorrectly defined P5. For example, Aplin *et al.*⁷ quoted the earlier definition, as did Sidi *et al.*,⁸ whereas others, such as Skaga *et al.*,⁹ have quoted the later, current ASA definition.

This persistent misquoting of the definition for P5 has implications for clinicians and investigators. It means that, unless a specific definition or reference is provided, it will not be clear to what “P5” refers. It also means that data from studies using the earlier definition cannot be compared directly to data from studies using the later definition. Of greater concern is the fact that many studies do not specify which definition of P5 has been used.

Whether P5 is used appropriately to describe patients' preoperative physical status, or less appropriately as a surrogate risk score, the ASA Physical Status Classification System, including P5, is used extensively in anesthesia and surgery. All clinicians and investigators should be aware of the current definition for P5, and be alert for the potential use of an incorrect definition, either defined or undefined.

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