

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.

MARK A. WANGLER, M.D.
Attending Staff

DELBERT E. CRANER, M.D.
Chief Resident

*Department of Anesthesia
Aultman Hospital
2600 Sixth Street, S.W.
Canton, Ohio 44710*

REFERENCES

1. Redick LF: An inflatable wedge for prevention of aortocaval compression during pregnancy. *Am J Obstet Gynecol* 133: 458-459, 1979
2. Elliott MB, King IR: A modified uterine displacement device. *ANESTHESIOLOGY* 57:146, 1982

(Accepted for publication December 18, 1984.)

Anesthesiology
62:701, 1985

Does ANESTHESIOLOGY Publish Too Little Clinical Material?

To the Editor:—In his 1983 Rovenstine Lecture on cardiovascular anesthesia,¹ 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 Anaesthetist* (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 non-anesthesia 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 anesthesiology is at its best when its clinical content contributes benefits to medicine at large.

DAN ANTONESCU-WOLF, M.D.
Assistant Professor of Clinical Anesthesiology

SIMON HALEVY, M.D.
Professor of Anesthesiology

*State University of New York at Stony Brook
Nassau County Medical Center
East Meadow, New York 11554*

REFERENCE

1. Keats AS: The Rovenstine Lecture, 1983: Cardiovascular anesthesia: Perceptions and perspectives. *ANESTHESIOLOGY* 60: 467-474, 1984

(Accepted for publication December 18, 1984.)