

Anesthesiology
66:721, 1987

Concerns Regarding the Obstetrical Anesthesia Survey

To the Editor:—The American Association of Nurse Anesthetists (AANA) declined to endorse the Obstetrical Anesthesia Survey, reported by Gibbs *et al.* in the September, 1986, issue of ANESTHESIOLOGY, because we were refused opportunity to provide input into the development of the questionnaire and methodology. Furthermore, we were concerned about possible unwarranted generalizations that are often associated with such studies, even when there is a lack of definitive data to support them. The Editorial in the September, 1986, issue of ANESTHESIOLOGY, is based on such generalizations.

While AANA agrees with Drs. Levinson and Shnider that obstetrical anesthesia coverage is a continuing problem, we believe they have drawn conclusions which have not been addressed by the study, *i.e.*, the actual linking of quality of obstetrical anesthesia to the particular provider. Until a study is performed which is designed to relate the anesthesia provider to obstetrical anesthesia

outcomes, opinions expressed by the editorial's authors remain purely that—opinions.

The statistics in the Gibbs *et al.*'s article clearly demonstrates that this problem will not be resolved by the American Society of Anesthesiologists (ASA) working in isolation of the AANA and its members. In fact, the ASA adoption of their position on regional anesthesia, *i.e.*, advocating that such techniques should be restricted to physicians with appropriate training, has the potential to exacerbate, rather than resolve, the obstetrical anesthesia problem.

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(Accepted for publication February 11, 1987.)

Anesthesiology
66:721–722, 1987

In Reply:—I am grateful for the opportunity to respond to Ms. McFadden's letter regarding the provision of obstetric anesthesia care in the United States.

It is indeed true that the AANA had no input into the survey design. The study was designed by a prestigious, independent research laboratory with input from those medical specialty societies that commissioned the survey out of concern for patient care. The results are discouraging—indeed, depressing—however, they would have been no more or no less so had the AANA participated in the survey design.

It is equally true that linking the quality of anesthetic care, *e.g.*, morbidity and mortality, to the provider is most desirable. This applies, however, not just to obstetric anesthesia care, but to all anesthetic care. A detailed, extensive, expensive survey of this type is currently in the planning stage.

The data presented by Gibbs *et al.*¹ are just that—data. Several conclusions may be drawn from these data that will obviously be interpreted in different ways by different people. However, the data, at least as I interpret them, do not indicate that this issue would be resolved by liaison between ASA and AANA.

On October 12, 1983, the House of Delegates of the ASA approved a "Statement of Regional Anesthesia." It

reads in part: "These guidelines and policy statements emphasize that anesthesiology is the practice of medicine and that anesthesia in all its forms, should be administered by, or under the direction of, a physician who is trained in the administration of anesthesia, preferably an anesthesiologist. Accordingly, anesthesiologists should assume responsibility for all aspects of anesthetic care, including obstetric anesthesia, outpatient anesthesia and anesthesia for emergency surgery. Spinal and other regional anesthesia procedures include diagnostic assessment, indications and contraindications, the prescription of drugs and the institution of corrective measures and treatment in response to complications, and not merely technical parts of patient care. In common with other medical practices these procedures require a sound basic science background and medical judgment." While this policy expresses the sentiment of the ASA, it is not binding on the membership. Indeed, we know of many instances where distinguished anesthesiologists do train nurse anesthetists in the techniques of regional anesthesia and where CRNAs do utilize the modalities. The essence of the matter, however, is expressed by Levinson and Schnider:² "The administration of general or regional anesthesia involves medical judgments, such as evaluation of appropriate techniques; choice of agents; management of both rare

and common anesthetic complications; and a knowledge of the interaction of anesthetic and obstetric drugs and of the impact of anesthesia on obstetric and medical complications, such as pre-eclampsia and heart disease. While most nurse anesthetists possess adequate, and often excellent, technical skills for the administration of an anesthetic, they are not trained as physicians and cannot be expected to make medical decisions." The situation was well, but less eloquently, stated by the late John Mulholland, Valentine Mott Professor of Surgery at New York University. He delighted in telling his students that "given 3 weeks, I can teach anyone to take out an appendix . . . I can't teach them when."

It should be recalled that the Survey in question was undertaken in 1981. At that time, there were 18,407 anesthesiologists, 8495 of whom were certified by the American Board of Anesthesiology. In 1986, these numbers had risen to 23,894 and 10,716, respectively. The problem will not simply be resolved by training and allowing nurse anesthetists to administer regional anesthesia. The questions are complex; they involve political, legal, regional, and financial, as well as medical, issues.

Anesthesiology
66:722, 1987

Low-dose Intranasal Nitroglycerine Attenuates Pressor Response

To the Editor:—Hill *et al.*¹ reported that intranasal administration of nitroglycerine (NTG) may be a convenient alternative to the intravenous route of administration. Subsequently, Fassoulaki and Kaniaris² used intranasal NTG successfully to prevent increase in arterial blood pressure following laryngoscopy and endotracheal intubation. However, they used a dose of 60 mg of NTG, which is 80 times more than the dose (0.8 mg) that is known to produce effective plasma levels after intranasal administration.¹ In order to evaluate the lower dose of NTG in preventing pressor responses to laryngoscopy and endotracheal intubation, we designed a double blind controlled trial on 40 adult patients, ASA I category, divided into two groups of 20 each. One of the groups received 0.75 mg of NTG intranasally 2 min before laryngoscopy. Anesthesia was induced with thiopental (4–6 mg/kg), and succinylcholine (1.5 mg/kg) was used to facilitate endotracheal intubation in all the patients. We failed to demonstrate the pressor response in our NTG group, while arterial blood pressure increased significantly in the control group during and after laryngoscopy and endotra-

cheal intubation. None of our patients suffered tachycardia or hypotension. We conclude that a lower dose of NTG (0.75 mg), administered intranasally, is a safe, rapid, and convenient method of attenuating pressor response to laryngoscopy and endotracheal intubation.

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(Accepted for publication February 12, 1987.)

Resolution will ultimately depend upon the demands of the marketplace.
Who devises surveys is irrelevant; our energies are best devoted to providing safe quality anesthetic and obstetric care for all. To that end, conversations continue between leaders of the obstetrical and anesthesia care teams. Let's get on with the job.

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(Accepted for publication February 11, 1987.)