

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.

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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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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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