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In Reply:—Waskell believes she should not alter her practice based upon our paper, citing the fact that rates of amputation were not statistically different before discharge. Amputation is performed for a number of possible indications other than inadequate tissue perfusion, *e.g.,* infection. It may be performed even when the graft is patent. Therefore, it is a less specific outcome related to graft patency than is reoperation.

Patients who must undergo reoperation, especially those with atherosclerotic vascular disease, are placed at significant risk, including major cardiac morbidity and death. Therefore, our finding of an increased rate of reoperation after general anesthesia should lead many anesthesiologists to favor epidural anesthesia.

Waskell also points out that the 6-month vascular surgery outcome was not different in the two groups. This is true as reported on table 2 in the paper.[1] However, by a lifetable-type analysis similar to that shown in figure 2,[1] the difference in outcomes at 6 months was significant ($P = 0.047$). This is because the rate of subsequent events remained similar for the two groups, as in figure 2 for the 1-month outcomes.[1] The difference in outcomes that was evident within the first 10 days after surgery never disappeared. It only diminished in importance relative to the high overall rate of reoperation. Many anesthesiologists would consider a reduction in perioperative graft failure a reason for modifying their practice.

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Reference

1. Christopherson R, Beattie C, Frank SM, Norris E, Meinert C, Gottlieb S, Yates H, Rock P, Parker S, Perler B, Williams GM: Perioperative morbidity in patients randomized to epidural or general anesthesia for lower extremity vascular surgery. ANESTHESIOLOGY 79: 422–434, 1993

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An Alternative Light Source for Laryngoscopy

To the Editor:—I would like to point out a useful technique for tracheal intubation in the patient with a bleeding tonsil or similar type of airway emergency.

In the past, while attempting to intubate the trachea of a child with a bleeding tonsil, I have found the laryngoscope bulb nonfunctional as the result of blood covering the lamp. Depending on the circumstances, almost complete loss of vision is experienced and landmarks cannot be visualized. Changing blades or laryngoscopes takes time, and the problem may recur. Secretions tend to do the same thing, but they are not as problematic as blood because the latter is more opaque. This problem could occur where there is pulmonary hemorrhage, and so on.

A technique that has worked well for me in dealing with this situation is as follows. Before induction, a headlight is secured in place and adjusted to the proper angle. Induction is carried out in the usual fashion, and laryngoscopy is performed using the headlight as the light source along with the usual laryngoscope blade light, if it functions properly. Vision of the cords and surrounding structures is good to excellent, even without light from the blade.

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A Matter of Degree[1]

To the Editor:—In 1674, Nicolas Boileau-Despréaux wrote, "Folly in all of every age we see, the only difference lies in the degree."[2] With all "deference due to a Man of Head Degree,"[3] the folly I would like to address here is ANESTHESIOLOGY's unique penchant for expressing temperature units in the form, "37° C."

Degrees on the Centigrade scale are analogous to millimeters of

mercury, which are abbreviated "37 mmHg" or rarely "37 mm Hg," but never "37mm Hg." The reason, of course, is that the Centigrade scale ("C") directly modifies the temperature unit ("°"), which in turn modifies the numeral. The Council of Biology Editors[4] and the International Union of Physiological Sciences Thermal Commission[5] both designate "37°C" as the proper format.

Requiring a space between the "°" and "C" characters produces ambiguity and confusion in the case of compound units. Consider the expression for the coefficient of heat transfer, having the units $J \cdot s^{-1} \cdot m^{-2} \cdot °C^{-1}$. If written $J \cdot s^{-1} \cdot m^{-2} \cdot °\ C^{-1}$, the integrity of the expression is lost, potentially confounding both the meaning and the reader. Adding to the confusion, the term "C^{-1}" appears so separate from the rest of the expression that typesetters sometimes interpret it as a discrete term and place it on a separate line or as the beginning of a new sentence.

Having established that the term "°C" is a unit, this leaves the matter of whether the degree symbol or a space should follow the numeral—degree or not degree, that is the question. The journals publishing most thermoregulatory research (*i.e., Journal of Applied Physiology, American Journal of Physiology, Journal of Thermal Biology, Aviation Space and Environmental Medicine*) leave no space between the numeral and degree symbol, *i.e.,* they format "°C" and "%" similarly (37°C or 4%). Other journals leave a space between numeral and degree, treating "°C" as they do units such as "kcal" (37 °C or 14 kcal). Either is acceptable, although I prefer the former.

In summary, I urge ANESTHESIOLOGY to format temperature units properly, just as "The heavens themselves, the planets, and this center, Observe degree, priority, and place."[6]

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References

1. Holmes OW Jr: LeRoy Fibre Co. *v.* C., M, & St. P, Ry., 232 U.S. 34°, 354, 1914

2. Boileau-Despreaux N: Le Satire. Naples, Tipografia Nella Pieta de'Turchini, 1826

3. Gilbert WS, Sullivan A: Ko-Ko, the Lord High Executioner, recounting the alleged beheading of Nanki-Poo to the most humane Mikado, The Mikado. Byeeson Treharne, D'Oyly Carte, 1940

4. CBE Style Manual Committee: CBE Style Manual: Guide for Authors, Editors, and Publishers in the Biological Sciences. 5th edition. Bethesda, Council of Biology Editors, 1983

5. IUPS Thermal Commission: Glossary of Terms for Thermal Physiology. 2nd edition. Eur J Physiol 410:567–587, 1987

6. Staunton H: The Complete Illustrated Shakespeare: Troilus and Cressida, Act 1, Scene 3. Originally published in 1609 under the title The Famous Historie of Troylus and Cresseid: Excellently Expressing the Beginning of Their Loves, with the Conceited Wooing of Pandarus Prince of Licia. New York, Park Lane, 1974

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In Reply:—Sessler is both correct and persuasive, and henceforth the Journal will designate temperature as __°C rather than __° C.

Lawrence J. Saidman, M.D.
Editor in Chief

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