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## Role of Epidural Anesthesia and Analgesia on Postoperative Patient Outcome

*To the Editor:*—The article by Liu *et al.*<sup>1</sup> provided a comprehensive review of the existing studies investigating the role of epidural anesthesia and analgesia on postoperative patient outcome. The discussion on the effects on the cardiovascular system, however, is misleading in that the authors did not differentiate between the studies of patients undergoing cardiac *versus* noncardiac surgery. Specifically, on page 1479, the authors cited that “intensive perioperative analgesia with large doses of systemic opioids can reduce myocardial morbidity and mortality.”<sup>2,3</sup> Furthermore, the authors cited that “myocardial infarction commonly occurs on the 3rd or 4th day after surgery, suggesting that aggressive therapy may need to be extended for at least 4 days.” The extrapolation of results from the two studies from cardiac to noncardiac surgery is not warranted. The study by Anand and Hickey<sup>2</sup> was performed in patients undergoing cardiac surgery for congenital cardiac defects, whereas the study by us was performed in patients undergoing coronary artery bypass graft surgery, when the use of intensive analgesia was shown only to reduce the severity of certain electrocardiographic ST-segment changes.<sup>3</sup> In this latter study, neither the incidence of myocardial ischemia nor the myocardial infarction rate (the study lacks power to determine whether there was a difference in infarction rate) differed between postoperative management techniques.

The etiology of why patients suffer postoperative myocardial infarction after cardiac surgery is likely to be very different from that after noncardiac surgery. To imply that one type of postoperative pain management or one type of prophylactic antiischemic therapy can suppress or eliminate postoperative cardiac complications is clearly an oversimplification. The mechanisms of postoperative myocardial ischemia or myocardial infarction are likely to be multifactorial when different clinical therapies must be employed. Furthermore, myocardial infarction after cardiac surgery typically occurs immediately after the procedure, with elevation of CPK-MB cardiac isoenzymes within the first 24 h after surgery and the appearance of

Q waves on postoperative 12-lead electrocardiogram by the 1st postoperative day.<sup>4</sup> Therefore, the time course of the occurrence of myocardial injury is different from that of noncardiac surgery. Ensuring that “postoperative analgesic regimen to be scientifically sound” as proposed by the authors would involve understanding the physiology of perioperative myocardial ischemia and infarction, an, as yet, unattained goal.

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## Should Renaming the Specialty Begin with the Journal?

*To the Editor:*—I was privileged to have heard in person the 33rd Rovenstine Lecture delivered by Lawrence Saidman, M.D., at the 1994 meeting of the American Society of Anesthesiologists and was grateful to see its text published in *ANESTHESIOLOGY*.<sup>1</sup> A major portion of the

lecture was devoted to a discussion of whether the name “anesthesiology” best serves the physicians who practice our medical specialty. As the breadth of our discipline has grown to encompass patient assessment and care beyond the intraoperative period and we have

## CORRESPONDENCE

come to issue certificates of special expertise in critical care medicine and pain management, it makes sense to many of us to consider a name for the parent specialty that is broader, more descriptive, and more accurate than "anesthesiology." In this vein, the suggestion of "metesthesiology" was forwarded to properly emphasize our role in altering (going "above and beyond") rather than eliminating the body's perception of noxious stimuli.<sup>2</sup> I was impressed by Saidman's arguments for a term not previously suggested: "perioperative medicine and pain management." This name emphasizes: (1) our specialty as a practice of medicine, (2) our role in guiding the patient safely through the totality of an invasive or painful procedure, and (3) our dramatic advances in the comprehensive treatment of pain from any cause.

Listening to Saidman's lecture and later reading the text, I was struck by the thought that there could not be a better way to initiate and lead such a change than by renaming our Journal. Obviously, such a change cannot be considered lightly and would require discussion and consensus among the Editorial Board of the Journal and the membership of the American Society of Anesthesiologists. If the name "perioperative medicine and pain management" is considered to better reflect the scope of our practice, does it not also better reflect the breadth of clinical and laboratory investigations that interest the readers of our Journal? An important part of the purpose of the American Society of Anesthesiologists as written in the Society's Bylaws is "to develop and further the specialty of anesthesiology."

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*In Reply:*—I appreciate McLoughlin's generous comments regarding the 1994 Rovenstine Lecture. Obviously, I agree with his suggestions *vis a vis* renaming the specialty but am less convinced that renaming the Journal would be appropriate. Although "perioperative medicine and pain management" may more precisely define our clinical job description, such a term does not begin to define the breadth of our anesthesia research—especially that concerned with basic science. How, for example, would research involving complex subcellular physiology and biochemistry, molecular genetics, magnetic resonance imaging, or theoretical modeling fit in a journal

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## Another Simple Method for Ring Removal

*To the Editor:*—Rings on the fingers of surgical patients usually should be removed preoperatively. Although rings frequently can be removed by thorough lubrication around the ring or the string-wrap method,<sup>1,2</sup> sometimes we are unable to remove rings using these methods, and, in an emergency, it is necessary to use a ring cutter. We would like to introduce a new simple method for ring removal.

ANESTHESIOLOGY is the Journal of the American Society of Anesthesiologists. Discussion about whether the name of our specialty should change and hence Saidman's specific suggestion of "perioperative medicine and pain management" have arisen because of the growth and development of our specialty. I like the name, as do many with whom I speak. Is it time for a change?

**Thomas M. McLoughlin, Jr., M.D.**  
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named "Perioperative Medicine and Pain Management"? Thus, because I agree that the specialty is, to some extent, constrained by its name, I would concentrate on renaming the specialty now and leave the Journal title unchanged until a term better describing the breadth of its contents can be agreed on.

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

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A finger part of a surgical glove cut off cylindrically is passed between the ring and the finger using small forceps as used for plastic surgery (fig. 1). The segment of the rubber beyond the ring is turned inside out and is pulled toward the fingertip with a twisting motion on the ring (fig. 2), thereby removing it.

This method has the advantage over the string-wrap method, which