CORRESPONDENCE

Technique for adnexal removal in vaginal hysterectomy

To the Editors:

The technique described by Smale and associates (AM. J. OBSTET. GYNECOL. 131:122, 1978) for adnexal removal at the time of vaginal hysterectomy, disturbs me greatly in the sense that it would, in my opinion, appear to defy principles of safe surgical technique.

First, a free tie is placed over tissues proximal to the clamp, placed for hemostasis on the infundibulopelvic ligament, "opening the clamp slightly, and then finishing the tie . . . ." I would be most concerned, without having transfixed the suture, that a blood vessel might retract as I was "finishing the tie." Therefore, in my opinion, the first suture placed should be of transfixion type and not a free tie.

Second, after the free tie has been placed, "all the vessels in the infundibulopelvic ligament are incorporated in a subsequent transfixion suture." In Fig. 1 this latter suture is shown to be placed lateral to the free tie. Again, I would be concerned that in the placement of the transfixion suture the needle might pass through a blood vessel and that one might develop a hematoma lateral to the suture. Therefore, in order to prevent development of a hematoma, it has always been my opinion that safe surgical technique requires the "free tie" to be placed lateral to the "transfixion suture" in this surgical adnexal extirpation.

Should my opinions prove wrong I shall be glad to be shown and accept the errors of my surgical technique; but if Smale and associates agree with my opinions it would, again in my opinion, be most important that they so publicize before too many gynecologists adopt the technique reported in the above-captioned article and potentially place their patients in jeopardy.

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Reply to Dr. Fribourg

To the Editors:

The authors thank Dr. Fribourg for his perception of an error in our illustration. It is our practice and our teaching to place the transfixion suture between the clamp and the free tie whenever possible for the reasons Dr. Fribourg stated.

However, he seems to misunderstand when the tie is placed and the reasons for its placement. It is placed prior to the excision of the adnexa; therefore, no vessels can retract, and it serves only to ensure complete incorporation of all pertinent tissues in the clamp. After the clamp is again securely locked, then, and only then, are the adnexal tissues excised.

Because of possible confusion illustrated by Dr. Fribourg's letter, I shall enumerate the steps for salpingo-oophorectomy as practiced by about 10 gynecologists in our community. An informal poll of them showed no significant hematomas, etc., arising.

1. When possible the fimbrial end of the tube is reflexed and incorporated into the tie encompassing the uterine end.
2. A strong (Heaney) clamp is placed carefully over the tissues of the broad ligament including the ovarian suspensory and infundibulopelvic ligaments. An initial small clamping and transfixion suturing may be necessary when the clamp will not easily transport across all the tissues to be clamped. This small clamping will include the round ligament and a portion of the mesosalpinx.
3. A free tie is placed and the clamp is opened slightly to allow the tissues to gather into the tie and the clamp.
4. Next the adnexa are excised 2 to 3 mm away from the clamp.
5. The transfixion suture is placed finally. Usually and preferably it is placed between the clamp and the free tie.

We thank Dr. Fribourg for giving us the opportunity to be a bit more specific about our surgical technique.

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Anesthesia in laparoscopic surgery

To the Editors:

The recent article by Caceres and Kim[1] provides an interesting alternative to the routine anesthesia for patients undergoing laparoscopic surgery. Unfortunately, it contains two inaccuracies which require correction. ASA classification refers to physical status as defined by the American Society of Anesthesiologists[2]

not the American Standards Association, as described in the article, or the American Surgical Association, as described elsewhere.[3] Additionally, fentanyl is the generic term for the preparation Sublimaze, as marketed by McNeil Laboratories. Innovar is the combination of fentanyl, a short-acting narcotic, with droperidol, a long-acting butyrophenone sedative.

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REFERENCES

1. Caceres, D., and Kim, K.: Spinal anesthesia for laparoscopic tubal sterilization, AM. J. OBSTET. GYNECOL. **131**:219, 1978.
2. Dripps, R., Eckenhoff, J., and Vandam, L.: Introduction to Anesthesia, The Principles of Safe Practice, ed. 5, Philadelphia, W. B. Saunders Co.
3. Goldman, L., et al.: Multifactional index of cardiac risk in noncardiac surgical procedures, N. Engl. J. Med. **297**:845, 1977.

To the Editors:

To my knowledge The American Standards Association has not concerned itself with the evaluation of patients' physical status. The ASA classification of physical status is that of the American Society of Anesthesiologists.

Fentanyl is *not* Innovar, as the article incorrectly suggests. Each milliliter of Innovar contains a combination of 2.5 mg of droperidol (a long-acting major tranquilizer) and 0.05 mg of fentanyl (a short-acting narcotic analgesic). Sublimaze contains only 0.05 mg of fentanyl. The effect of fentanyl alone is substantially different from the effect of Innovar. Which drug the authors actually used is unclear.

The data presented are not sufficient to allow evaluation of the study.

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Reply to Drs. O'Connor and Plumer

To the Editors:

The manuscript which we submitted originally read: "All patients were classified A.S.A.I.," which was expanded by the publishers as "American Standards Association," which we did not intend. It should have been written as ASA (American Society of Anesthesiologists). The original manuscript also read: "administration of 1 cc of Innovar intravenously." We are aware that Innovar is a combination of fentanyl and droperidol.

We are very thankful to Drs. O'Connor and Plumer for bringing out the mistakes which were inadvertently overlooked at the time of publication.

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More on "precise" infant mortality rates

To the Editors:

The purpose of a previous communication (del Pinal and Cowan: THIS JOURNAL 130:371, 1978) was not to denigrate the work of Dott and Fort (THIS JOURNAL 123:847, 1975). Rather, we desired to share a concept, "population at risk," which has been useful for quite some time in increasing the precision of mortality rates. Of course, the concept presumes interest in measuring mortality risks as accurately as possible given the data.

I feel that an important function of a journal of this caliber is to disseminate the results of scientific research and stimulate constructive criticism. Thus, I find it disquieting that we should be upbraided by Van Peenen and Gundelfinger (THIS JOURNAL 132:704, 1978) for presuming to offer just such a critique. Furthermore, Van Peenen and Gundelfinger seem to imply that there exists a statute of limitations (2 years?) on critiques of published work. However, the most troublesome aspect of their correspondence is the autocratic manner in which they dismiss unfamiliar measures of risk.

According to Van Peenen and Gundelfinger, we committed a "grievous error" in summing the neonatal mortality rate (neonatal deaths × 1,000/live births) and a redefined postneonatal mortality rate (postneonatal deaths × 1,000/[live births − neonatal deaths]). It seems strange that these authors became so incensed at our procedure in creating a "new" infant mortality rate. After all, they prefaced their communication with a paragraph to the effect that ". . . mortality rates may have different meanings for different authors" and that ". . . conscientious authors define exactly what went into . . . their rates." Obviously, they had little trouble ascertaining what went into our rates, and yet, "on this score" we did not "rate high marks." However, I completely reject their unsupported assertion that we ". . . surrendered the right to sum . . ." the components as we defined them. We merely give up the right to call it a mortality rate *per 1,000 live births.* Instead, it is the mortality rate *per 1,000 infants at risk* during the periods considered (i.e., the neonatal and postneonatal periods of infancy).

Our rate is the sum of the conditional probability of dying before reaching 28 days of age (the neonatal