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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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