“Locality rule” standard of care expands

In the last 15 years, medical malpractice has been extended beyond suits against physicians to encompass suits against hospitals and non-physician health care practitioners, including dentists, chiropractors, and nurses. The standard of care by which these practitioners are held comports with the standards by which physicians are held, that is, they are compared with the skills and care the reasonable dentist, chiropractor, or nurse possesses.

The last 15 years have also witnessed a change in the standards of care, ostensibly for physicians, but in reality for all practitioners. Starting with the development of the locality rule, the standard of care has been expanded to what now could be called the national rule.

The locality rule was developed in the late 19th century. A leading case in its development is Small v. Howard, 128 Mass. 131, 132 (1880) in which a general practitioner in a small village was sued for negligence. The court held that the defendant physician “was not bound to possess that high degree of art and skill possessed by eminent surgeons practicing in larger cities.” Thus emerged the beginning of the locality rule.

In its original concept, the locality rule made allowances for the type of community in which the physician conducted his practice. Its premise was that the rural physician had neither the sophisticated equipment, facilities, libraries, and professional assistance nor did he have the same opportunities for keeping informed of current advances in medicine as those possessed by professional counterparts practicing in larger cities. Therefore, the character of the locality or neighborhood in which the physician practiced had an important bearing on the degree of care and skill that was required of the physician.

Because of the disparity between the rural and urban physician, most states adopted the locality rule, whereby a physician is to be judged by the standards in the locality in which he practices. He is also required to possess and exercise that degree of skill and care ordinarily employed in similar circumstances by physicians of good standing in his own community.

Although the locality rule still exists in most states, many have updated the rule and expanded it in recognition of the significant advances within the medical profession. Because of improved methods of communication, the frequency and accessibility of medical seminars, improved modes of communication, and increased opportunities for consultation with specialists, rural physicians are expected to achieve the same level of skill and care as those practiced by their counterparts in the cities. In many states, the community is now just one of several factors taken into account in applying the general professional standards.

This updating and expansion began in the late 1960’s when many states rejected the strict locality rule and began applying the similar locality rule. One such leading case was Pederson v. Dumouchel, 431 P.2d 973, 976 (Wash. 1967) in which the Washington Supreme Court determined the standard of care to be the learning, skill, care and diligence ordinarily possessed and practiced by others in the same profession in good standing, engaged in like practice, and in the same locality or similar localities. (Emphasis added.)

National standard of care

Although most states now adhere to the similar locality rule, the growing trend is the development of a national standard of care. The
The seminal case in this development is Brune v. Belinoff, 235 N.E. 2d 793 (Mass. 1968) in which an anesthesiologist was sued for alleged negligence in administering an excessive injection of tetracaine to a woman in childbirth. The physician practiced in a city of 100,000 and was located approximately 50 miles from Boston.

The anesthetic contained 8 mg of tetracaine in one cubic centimeter of a 10% glucose solution. The plaintiff’s evidence showed that good medical practice called for a dosage of only 5 mg or less. The defendant showed that 8 mg was customary in his city.

Although the jury found for the defendant, the Appellate Court reversed the decision saying, “We are of the opinion that the ‘locality’ rule . . . which measures a physician’s conduct by the standards of other physicians in similar communities, is unsuited to present day conditions. The time has come when the medical profession should no longer be Balkanized by the application of varying geographic standards in malpractice cases.” With this, the court adopted a national standard of care for physicians.

Statute-developed standard of care

Although the standard of care is developed by the courts in many states, some states address this issue by statute. A recent court interpretation of such a statute has given significant impetus to the development of the national standard of care. In Drs. Lane, Bryant, Eubanks & Dulaney v. Otts, 412 So.2d 254 (Ala. 1982), the plaintiff sued a group of physicians for medical malpractice based on negligence of the physicians and their employee, a certified registered nurse anesthetist.

The group’s procedure was to allow the CRNA to handle the anesthesia management of patients from the beginning of a surgical procedure until the end without the presence of the anesthesiologist. During the surgical procedure focused on in this case, the CRNA had difficulty ventilating the patient through the endotracheal tube. Although an anesthesiologist was in the next operating room, the CRNA did not call him until the patient suffered a cardiac arrest. The patient suffered severe brain damage and died six weeks after surgery.

The patient’s family (plaintiff) attempted to show through expert testimony that the failure of the CRNA to call for help at the moment she had difficulty ventilating the patient was a departure from accepted medical standards. However, the defendant relied on the Alabama statute stating the standard of care for physicians: “In performing professional services for a patient, a physician’s . . . duty to the patient shall be to exercise such reasonable care, diligence and skill as physicians . . . in the same general neighborhood, and in the same general line of practice, ordinarily have and exercise in a like case.” (Emphasis added) Code of Alabama, 1975, §6-5-484(a).

Although the jury returned a verdict for the plaintiff, on appeal the Alabama Supreme Court reversed the decision based on its interpretation of the Alabama statute. The court interpreted the statute’s language which holds the physician to that standard of care as practiced by physicians in the “same general neighborhood” as meaning that physicians are held to the standard of care practiced by physicians in a “national medical neighborhood or national medical community, of reasonably competent physicians in the same line of practice acting in the same or similar circumstances.” (Emphasis added.)

In expanding the state’s statutory “locality rule” to a national standard, the court cited practical difficulties of the former rule: Scarcity of professional people in a locality qualified to testify to the local standard of care and the possibility that a negligent standard of care has become acceptable to a small and close community of physicians in a narrow geographic region. The court held that distinctions in the degree of care and skill to be exercised by physicians in the treatment of patients based on geography could no longer be justified in light of the presently existing state of transportation, communications, and medical education and training which results in a national standardization of care within the medical profession.

Conclusion

The nationalization of the “locality rule” statute by Otts is based on the realities existing in the present day national medical world, community and neighborhood. The decision logically recognizes that today there is no lack of opportunity for health care professionals and practitioners to keep abreast of the advances made in the medical world and to be familiar with the latest methods, procedures, and practices adopted within each profession and practice.

Given the expansion and nationalization of the “locality rule” by the courts as exemplified by the Alabama Supreme Court’s liberal interpretation of Alabama’s standard of care statute, each health care professional and practitioner may soon find himself or herself confronted with a nationwide standard of care and skill regardless of where he or she practices.
Announcing a new anesthetic concept that provides maximum protection prior to maximum stress
Introducing a new anesthetic technique:

This new technique—pre-intubation analgesic loading—involve administering enough SUBLIMAZE® (fentanyl) prior to intubation to last generally the length of the procedure. Pre-intubation upfront loading employs the pharmacokinetic properties of SUBLIMAZE® (fentanyl) to best advantage compared with p.r.n. use or administration of the drug incrementally throughout the procedure.

For further information and general guidelines on pre-intubation analgesic loading with SUBLIMAZE® (fentanyl), please contact your Janssen representative or write Janssen Pharmaceutica.

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Pre-intubation analgesic loading with

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(fentanyl) Injection C

1. Provides maximum protection just prior to anesthetic and surgical stress
Upfront loading immediately before intubation puts the maximum amount of Sublimaze® (fentanyl) on board just prior to laryngoscopy, intubation and incision, the stimuli responsible for maximum stress. (Sublimaze helps attenuate rises in blood pressure and pulse rate.)

2. Eliminates “chasing the patient”
This new technique helps prevent sympathetic breakthrough and all the problems that stem from “chasing the patient.”

3. Permits most patients to breathe spontaneously at completion of surgery*

4. Reduces need for postoperative narcotics
Postoperatively, residual plasma and tissue levels provide sufficient analgesia to minimize the need for additional narcotics.

Pharmacokinetics of a single I.V. dose of 6.4 μg/kg fentanyl base in man

Slightly depressed spontaneous respiration below 1.5 ng/ml; normal respiration below 0.7 ng/ml.

*Note: Respiratory depression may last longer than analgesic action and this risk increases with increasing doses.


Available in easy-to-use 10 ml ampoules

Please see brief summary of Prescribing Information on next page.
Sublimaze® (fentanyl) Injection

Protect from light. Store at room temperature.

Before prescribing, please consult complete prescribing information, of which the following is a brief summary.

PRECAUTIONS

AS WITH OTHER CNS DEPRESSANTS, PATIENTS WHO HAVE RECEIVED SUBLIMASE® (fentanyl) SHOULD HAVE APPROPRIATE SURVEILLANCE.

RESULTS OF EYE EXAMINATION AND A NARCOTIC ANTAGONIST SHOULD BE READILY AVAILABLE TO MANAGE APNEA.

See also discussion of narcotic antagonists in Precautions and Overdosage. If SUBLIMASE® (fentanyl) is administered with a tranquilizer such as INAPSINE® (droperidol), the user should familiarize himself with the special properties of each drug, particularly the widely differing duration of action. In addition, when such a combination is used, fluids and other countermeasures to manage hypotension should be available.

As with other potent narcotics, the respiratory depressant effect of SUBLIMASE® (fentanyl) may persist longer than the measured anesthetic effect. The total dose of all narcotic anesthetics administered should be considered by the practitioner before ordering narcotic anesthetics during recovery from anesthesia. It is recommended that narcotics, when administered postoperatively, be titrated individually, as in those usually recommended. SUBLIMASE® (fentanyl) may cause muscle rigidity, particularly involving the muscles of respiration. The effect is related to the speed of injection. If muscle rigidity occurs, it is usual to use slow intravenous injection. Once the effect occurs, it is managed by the use of assisted or controlled respiration and, if necessary, by a neuromuscular blocking agent combination. For patients with known history of convulsions, it is advisable to have adequate facilities for postoperative observation, and ventilation if necessary, for patients who have received SUBLIMASE® (fentanyl). It is essential that these facilities be fully equipped to handle all degrees of respiratory depression.

Drug Dependence—SUBLIMASE® (fentanyl) can produce drug dependence of the morphine type and, therefore, has the potential for being abused.

Severe and unpredictable potentiation by MAO inhibitors has been reported with narcotic antagonists. Since the safety of fentanyl in this regard has not been established, the use of SUBLIMASE® (fentanyl) in patients who have received MAO inhibitors within 14 days is not recommended.

SUBLIMASE® (fentanyl) should be used with caution in patients who may be particularly susceptible to respiratory depression, such as combative patients who may have a head injury or brain tumor. In addition, SUBLIMASE® (fentanyl) should not be used in patients with head injury.

Usage in Children—The safety of SUBLIMASE® (fentanyl) in children younger than two years of age has not been established.

Usage in Pregnancy—The safe use of SUBLIMASE® (fentanyl) has not been established with respect to possible adverse effects on the developing fetus. It should be used in pregnant women only if the potential benefit justifies the potential risk to the fetus.

When fentanyl is used in combination with other agents for postoperative analgesia, the dose of fentanyl should be kept to a minimum. When required for postoperative analgesia, the dose of fentanyl should be kept to a minimum. When required for postoperative analgesia, the dose of fentanyl should be kept to a minimum.

When used with a tranquillizer such as INAPSINE® (droperidol), blood pressure may be altered and hypotension can occur.

Vital signs should be monitored routinely.

SUBLIMASE® (fentanyl) should be used with caution in patients with chronic obstructive pulmonary disease, specific pulmonary conditions, or with potentially compromised respiration. In such patients, narcotic analgesics may add to the respiratory depression.

High dose—20-50 mcg. (.02-.05 mg.)(0.4-1 ml.) SUBLIMASE® injection. Where surgery becomes more major, a larger dose is required. With this dose, in addition to adequate analgesia, one would expect to see some abolition of the stress response. However, respiratory depression will be such that artificial ventilation during anesthesia is necessary, and careful observation of ventilation postoperatively would be detrimental to the well being of the patient. Dosages of 30-50 mcg. (.02-.05 mg.)(0.4-1 ml.) SUBLIMASE® injection with nitrous oxide may be employed to maintain the stress response as defined by increased levels of circulating growth hormone, catecholamine, ADH, and prolactin.

With a known history of convulsions, doses of SUBLIMASE® (fentanyl) are employed, even relatively small dosages of diazepam may cause cardiovascular depression. Other CNS depressants (e.g. barbiturates, tranquilizers, narcotics, and general anesthetics) will have additive or potentiating effects with SUBLIMASE® (fentanyl). When patients have received such drugs, the dose of SUBLIMASE® (fentanyl) required will be less than usual. Likewise, following the administration of SUBLIMASE® (fentanyl), the dose of other CNS depressant drugs should be reduced.

SUBLIMASE® (fentanyl) should be administered with caution to patients with liver and kidney dysfunction because of the importance of these organs in the metabolism and excretion of drugs. SUBLIMASE (fentanyl) should be administered with caution to patients with liver and kidney dysfunction because of the importance of these organs in the metabolism and excretion of drugs.

SUBLIMASE® (fentanyl) SHOULD HAVE

INAPSINE

INAPSINE

NDC 50458-030-10 NDC 50458-030-65

HOW SUPPLIED

2 ml. and 5 ml. ampoules—packages of 10


NDC 50458-030-02-02 NDC 50458-030-05

20 ml. and 20 ml. ampoules—packages of 5

(For intravenous use by hospital personnel specifically trained in the use of narcotic antagonics)
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One great new monitor on top of another. Introducing the Datascope 2000.
The 2000 monitor is a new monitor for the anesthesiologist that we believe is great. Here is why we think you'll have to agree.

**It’s impressively small**
The 2000 monitor displays more information than many larger monitors. It displays the ECG and two pressure waveforms simultaneously as well as heart rate, all pressure values and two temperatures. It automatically trends all information for four hours. It can even be operated from its integral battery.

**It displays information better**
The 2000 monitor only displays information if a parameter is being monitored. Since some information is more important than other information, the 2000 monitor makes these displays brighter. All information is shown continuously, so there is no need to give up one value for another.

To help with pressure measurements, a unique adjustable reference trace provides a precise visual indication that marks pressure changes and values. This reference trace automatically becomes a trend reference trace when any of the 2000 monitor’s four-hour trends for each parameter is recalled.

**It’s easy to use**
Only a few touch-sensitive front-panel keys control the three traces, all 17 digital displays and complete trend information. The 2000 monitor recognizes and filters out ESU noise with its integral electrosurgical interference suppression. It constantly checks the ECG, pressure, or pulse waveforms for variability and determines heart rate from the most reliable source automatically.

It knows whether you are using three or five electrodes for monitoring and automatically adjusts the lead selections available to three or 12 leads. The 2000 monitor even formats trend information so that the most recent 15 minutes are shown in expanded scale.

Lastly, if the 2000 monitor offers more than you need, there are two other monitors which are just as great—the 2001 and the 2002. All three monitors incorporate the design detail, reliability and bright, precise displays which Datascope customers have come to expect.

**It’s the start of a system**
As our headline suggests, the new 2000 monitor follows the recent introduction of our ACCUTORR® non-invasive blood pressure monitors. Chances are you already know about them. The relationship between the 2000 monitor and the ACCUTORR is more than chronological. Together, these two compact monitors form a unique system. The 2000 monitor will trend and display non-invasive blood pressure measurements. These two monitors, one on top of the other, meet your monitoring requirements from the most basic to the most complex—every day.

Like the ACCUTORR, future Datascope products can be added as part of the 2000 monitoring system, because additional trending and display capabilities are a special feature of the 2000 monitor.

We believe the 2000, 2001 and 2002 monitors represent the finest achievement yet in our long standing commitment to the anesthesiologist. This commitment begins with product development and continues through conscientious support and service worldwide.

For additional information on these monitors or a demonstration, write Datascope Corp., Dept. 5Q, 580 Winters Ave., P.O. Box 5, Paramus, N.J. 07652; or call (201) 265-8800.
showed that Ketalar, administered by dilute continuous drip infusion concurrently with administration of diazepam, muscle relaxants, and nitrous oxide-oxygen, provides satisfactory anesthesia and visceral analgesia for major surgery and a smooth emergence period without prolongation, delirium, or dreaming. The incidence of emergence phenomena was reduced to less than 1%, as compared to approximately 12% when Ketalar had been used as the sole anesthetic agent.

Now the scope and usefulness of Ketalar have been broadened to include a wider range of surgical procedures whenever an injection anesthetic is preferred.

Ketalar low-risk anesthesia for the high-risk patient.

Please see next page for brief summary of prescribing information.

**Ketalar®**
(Ketamine Hydrochloride Injection, USP)

Before prescribing, please see full prescribing information. A Brief Summarizes.

### CONTRAINDICATIONS

Ketamine hydrochloride is contraindicated in those in whom aspirin-sensitization or who have experienced severe reactions to ketamine are not reversible and may cause respiratory depression or apnea and enhanced muscarinic effects. Therefore, it should be used with caution when administered to patients with preanesthetic elevated cerebrospinal fluid pressure.

### ADVERSE REACTIONS

Cardiovascular: Hypotension, bradycardia, and/or bradycardia may occur following rapid intravenous administration of high doses of Ketalar. Laryngospasms and other forms of airway obstruction have occurred during Ketalar anesthesia.

Psychological: Dream-like observations and emergence delirium. In some cases, these reactions have been serious. Delirium has been more common in children and/or in those who are elderly (over 65 years of age) or in those who have been premedicated with agents such as nitrous oxide. Waking confusion has also been noted after emergence from anesthesia. The psychological manifestations vary in approximately 12 percent of patients. Psychological manifestations may be accentuated by the simultaneous use of diazepam, or other sedatives or hypnotics.

### DOSAGE AND ADMINISTRATION

**Induction:** The initial dose of Ketalar administered intramuscularly may range from 6.5 to 13 mg/kg (3 to 6 mg/lb). A dose of 10 mg/kg (5 mg/lb) will usually produce 10 to 15 minutes of surgical anesthesia.

**Maintenance of Anesthesia:** The maintenance dose should be adjusted according to the patient's anesthetic needs and whether an additional anesthetic agent is employed. Increments of one-half to the full induction dose may be repeated as needed for maintenance of anesthesia. However, it should be noted that purposeless and tonic-clonic movements of extremities may occur during the course of anesthesia, although these movements do not imply light plane and are not indicative of the need for additional doses of the anesthetic.

It should be recognized that the larger the total dose of Ketalar administered, the longer will be the time to complete recovery.

**Ketalar Steri-Vials, 10 mg/ml are not recommended for dilution.**

**Information for Patients**

As appropriate to the cases in which early discharge is possible, the duration of Ketalar and other drugs employed for anesthesia should be considered. The patients should be cautioned that driving an automobile, operating hazardous machinery, or performing hazardous activities should not be undertaken for 24 hours or more (depending upon individual and/or minor consideration of other drugs employed) after anesthesia.

### Drug Interactions

Prolonged recovery time may occur if barbiturates and/or narcotics are used concurrently with Ketalar. Ketalar is significantly reduced by premedication with barbiturate or local anesthetic agents when an adequate respiratory exchange is considered when selecting the appropriate anesthetic agent.

### Warnings and Dosage and Administration Sections of the Drug Label

The use of diazepam, or other sedatives or hypnotics, may cause a slight elevation in intracranial pressure resulting in a decrease of cerebral blood flow and cerebral oxygenation. Therefore, the use of diazepam, or other sedatives or hypnotics, is not recommended for patients with preanesthetic elevated cerebrospinal fluid pressure.

### Local Pain and Exanthema at the Injection Site

Local pain and exanthema at the injection site may occur.

### Dilution:

To prepare a dilute solution containing 1 mg of ketamine per ml, aseptically transfer 10 ml of Ketalar Steri-Vials, 10 mg/ml into a 5-ml vial of sterile water for injection. The 100 mg/ml concentration of Ketalar (Ketamine hydrochloride) is not recommended for use in infants and children. The 100 mg/ml concentration of Ketalar may be used in patients weighing 70 kg or more.

### Preparatory Preparations:

1. Wdma has been reported following Ketalar administration, some airway protection may be afforded because of increased pharyngeal reflexes. However, since aspiration may occur with Ketalar and since protective reflexes may also be diminished by subsequent drying agents, such as atropine and/or scopolamine, the possibility of aspiration must be considered. In the judgment of the practitioner, the benefit of the drug outweigh the possible risks. In the judgment of the practitioner, the benefit of the drug outweigh the possible risks.

2. Atropine, scopolamine, or another drying agent may be used to produce drying of the mouth shortly after regaining consciousness (see Special Note). The resultant solution will contain 1 mg of ketamine per ml. The fluid requirements of the patient and duration of anesthesia must be considered when selecting the appropriate anesthetic agent.

### Dilution:

To prepare a dilute solution containing 1 mg of ketamine per ml, aseptically transfer 10 ml of Ketalar Steri-Vials, 10 mg/ml into a 5-ml vial of sterile water for injection. The resultant solution will contain 1 mg of ketamine per ml. The fluid requirements of the patient and duration of anesthesia must be considered when selecting the appropriate anesthetic agent.

### Additional Information on the use of diazepam, refer to the Warnings and Dosage and Administration Sections of the Drug Label.

**HOW SUPPLIED**

Ketalar is supplied as the hydrochloride in concentrations equivalent to ketamine base.

N 0071-4581-15—Each 50 ml vial contains 1 mg/ml; Supplied in cartons of 15 N 0071-4581-13—Each 25 ml vial contains 1 mg/ml; Supplied in cartons of 10 N 0071-4581-12—Each 20 ml vial contains 1 mg/ml; Supplied in cartons of 10 N 0071-4582-10—Each 10 ml vial contains 1 mg/ml; Supplied in cartons of 100 N 0071-4585-06—Each 5 ml vial contains 100 mg/ml; Supplied in cartons of 10

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If there's one thing anesthesiologists seem to value as much as quality in anesthesia trays, it's efficiency. That's what we heard time and time again from doctors and C.R.N.A.'s.

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Two minutes to appreciate.
When patients would rather not remember...
premedication with Ativan® (lorazepam)
Injection IM or IV
effectively reduces recall of events surrounding surgery

- Allays preoperative apprehension
- Leaves patients calm but cooperative
- Causes little, if any, IV irritation
- Rated “highly acceptable” by most patients in clinical studies

Surgical procedures are perceived as frightening or unpleasant by most patients. If given the opportunity, many would rather not remember anything about the ordeal.

Ativan® Injection can help. Administered as recommended, Ativan Injection helps sedate the patient, relieves presurgical anxiety and diminishes recall of events surrounding surgery.

The dosage of Ativan Injection should be individualized for each patient. For those patients in whom a lack of recall and excellent sedation are desired, doses of 0.05 mg/kg up to a maximum of 4 mg should be administered. For patients in whom a lack of recall is not desired, as well as for the elderly or debilitated, the dose of Ativan Injection should be reduced.

See important information on following page.
DESCRIPTION: Ativan (lorazepam) injection, Wyeth, is available in multiple-dose vials and in TUBEX Sterile Concentrate for Injection. 30-month stability data have been completed. Pre-incubation study in rats, performed with oral lorazepam at a 20 mg/kg dose, showed no impairment of fertility. 

CLINICAL PHARMACOLOGY: For IV administration of recommended dose of 2-4 mg lorazepam injection to adults, the median time to onset of action is less than 1 hour. 

Dosage and Administration: Maintain adequate airway and assist respiration. In serious cases ataxia, hypotonia, hypotension, stages one to three coma, and very rarely death. Treat seizures as indicated. IV injection before lorazepam was given). 

Cardiogenic Edema, Hypotension, Impairment of Fertility: No evidence of carcinogenic potential emerged in oral dosing studies. Concerning hepatocellular adenomas and carcinomas were observed in rats on the 20 mg/kg dose. 

Eye-hand coordination, data are insufficient to predict when it would be safe to operate a motor vehicle or engage in hazardous occupation or sport. 

In some studies, none of the doses of lorazepam injection did not greatly affect the circulatory system in the supine position or implying a 70 degree tilt test. Doses of 8-9 mg of IV lorazepam (2 to 2.5 times maximum recommended dose) did not produce significant hypotension or bradycardia within 15 minutes. 

Studies in 6 healthy young adults who received lorazepam injection and no other drugs revealed that visual tracking ability (ability to keep a moving line in focus) was impaired for a mean of eight (8) hours following 4 mg IV lorazepam and four (4) hours following 2 mg IV with considerable subject variation. Similar findings were noted with peroneal muscle EDX studies. This study showed both lorazepam and pentobarbitol induced with eye-hand coordination, data are insufficient to predict when it would be safe to operate a motor vehicle or engage in hazardous occupation or sport. 

In studies with patients—adults, for parenteral anesthetic, producing sedation (sleepiness or drowsiness), relief of anxiety, and decreased ability to recall events related to day of surgery. Most useful in patients stress-induced hypertension and lack of recall of events related to day of surgery in most patients. The clinical sedation (sleepiness or drowsiness) was not significantly greater than control. 

Lorazepam injection is an effective and relatively safe drug for pre-anesthetic medication. Lorazepam injection decreases the amount of air in half-filled TUBEX. (2) Slowly aspirate desired volume of diluent. (3) Pull back slightly on plunger to determine amount of air in TUBEX. If air is aspirated, discard and draw up another amount of sterile TUBEX. 

TUBEX: Ativan injection is supplied in a white, cotton-lined, self-sealing, plastic, disposable device designed to minimize air injection site (redness) occurred in about 2% (17/859) in immediate post-injection period, and were present 24 hours in 5% (43/859) of patients. At 30 days post-injection and 4 hours later (77/859) patients or 0.5% (40/859) of patients. Redness did not occur immedi- 

There are insufficient data to support lorazepam injection for outpatient endoscopic procedures. Ingested endoscopic procedures require adequate recovery room observations. Pharyngeal reflexes are not impaired when lorazepam injection is used for oral and nasal endoscopic procedures, therefore adequate topical or regional anesthesia is recommended to minimize reflex activity associated with such procedures. 

In the treatment of acute or chronic anxiety, and for the treatment of alcohol withdrawal syndrome, lorazepam injection is used as an adjunct to a program of psychological stabilization. 

Cardiovascular System: Hypertension (0.1%) and hypotension (0.1%) were occasionally observed after patients received injectable lorazepam. 

The eye is the most likely site of conjugation and since exclusion of conjugated lorazepam (glucuronide), is renal, lorazepam injection is not hepatic and/or renal failure. This does not preclude its use in patients with mild to moderate hepatic dysfunction. 

Other USES: Injection during anesthesia and surgery. Immediately prior to IV use, lorazepam injection must be diluted 1:2 with 0.9% sodium chloride solution or D5W. 

Lorazepam is a benzodiazepine with antianxiety and sedative/hypnotic effects, including amnesia. Lorazepam injection, Wyeth, is available in multiple-dose vials and in TUBEX Sterile Concentrate for Injection. 30-month stability data have been completed. Pre-incubation study in rats, performed with oral lorazepam at a 20 mg/kg dose, showed no impairment of fertility. 

Laboratory Tests: In clinical trials, laboratory test abnormalities were identified in single or multiple doses of lorazepam injection. Tests included: CRP, urinalysis, BUN, SGPT, SGOT, sodium, potassium, chloride, glucose, lipase, amylase and alkaline phosphatase. 

There are insufficient data to support lorazepam injection for outpatient endoscopic procedures. Ingested endoscopic procedures require adequate recovery room observations. Pharyngeal reflexes are not impaired when lorazepam injection is used for oral and nasal endoscopic procedures, therefore adequate topical or regional anesthesia is recommended to minimize reflex activity associated with such procedures. 

Studies have shown that 2-4 mg IV or IM of lorazepam may produce a profound sedation, temporarily disrupting memory and awareness of the surroundings. 

In some studies, none of the doses of lorazepam injection did not greatly affect the circulatory system in the supine position or implying a 70 degree tilt test. Doses of 8-9 mg of IV lorazepam (2 to 2.5 times maximum recommended dose) did not produce significant hypotension or bradycardia within 15 minutes.