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OCT 28 1985

October 18, 1985

J. H. Modell, M.D., Chairman

Joseph P. Ornato, M.D.
 Chief, Section of Emergency Medical Services
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 Section of Emergency Medical Services
 P.O. Box 525
 Richmond, Virginia 23298-0001

Dear Joe:

Thank you for your memorandum of October 8, 1985. As you know, I have been out of town for two weeks, and, therefore, even though we tried to contact each other by telephone, we were unable to do so, which explains my tardy response.

I have read your memorandum as well as the letter you received from Dr. Heimlich. For the most part, I believe that Dr. Heimlich has overstated the case. There is one area in which he and I significantly disagree; this is the interpretation of research done in my laboratory. Dr. Heimlich apparently feels that my studies indicate that a large amount of water is aspirated by drowning victims. On the other hand, my interpretation of my results is that a modest amount, or, in some cases, a very small amount of water is aspirated by drowning persons. You will recall at the panel, he emphasized the fact that we had performed studies indicating that as much as "22 ml/kg of water could be aspirated," whereas I emphasized that "less than" 22 ml/kg was aspirated. Further, you will recall the analogy that I made with the glass of water demonstrating that, when one compares this amount of aspirated fluid to the total lung volume, it indeed is a small, or modest, amount. Thus, I believe that your interpretation of my studies is far more correct than Dr. Heimlich's interpretation.



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Joseph P. Ornato, M.D.

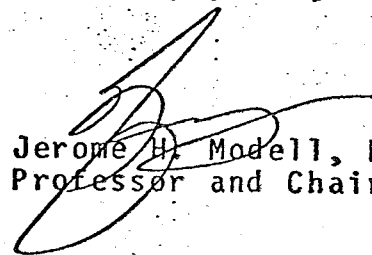
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I believe that Dr. Heimlich's statement that you may be condemning people to die by depriving them of the subdiaphragmatic abdominal thrust significantly overstates his case. I do believe that, because of the potential risk of regurgitation and aspiration, the subdiaphragmatic abdominal thrust should definitely be used only when the rescuer suspects that foreign materials are obstructing the airway. On the other hand, as I said on the panel, if the victim does not respond to standard techniques of cardiopulmonary resuscitation, particularly to mouth-to-mouth ventilation, then, I believe, the risk of aspiration might be acceptable, and the subdiaphragmatic abdominal thrust may be indicated. I believe that this can be borne out on page 3 of your recommendations, which currently state the following: "Since the risk/benefit ratio of an abdominal thrust in this setting is unknown, the only time it definitely should be used is when the rescuer suspects that foreign matter is obstructing the airway." I would suggest that you consider editing this to read as follows: "Since the risk/benefit ratio of an abdominal thrust in this setting is unknown, the only time it definitely should be used is when the rescuer suspects that foreign matter is obstructing the airway. However, some believe that if the victim does not respond appropriately to mouth-to-mouth ventilation, a subdiaphragmatic abdominal thrust may be indicated, after which basic CPR should be reinstated."

Joe, please feel free to send copies of this letter to any persons that you deem appropriate. With best regards.

Sincerely yours,



Jerome H. Modell, M.D.
Professor and Chairman

JHM/klg

