

tive, it is imperative that the data conveyed be exact.

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Heimlich Maneuver or Chest Thrust or ?

As an American Heart Association (AHA) instructor in basic life support to dental auxiliary students and the public since 1981, I read Surgeon General Koop's editorial ["The Heimlich Maneuver"] in the November-December issue of *Public Health Reports* with a great deal of interest.

Dr. Heimlich's long-standing objection to use of back blows for treatment of the obstructed airway is well known. One result of this difference of opinion is avoidance by AHA of the term "Heimlich Maneuver" in its publications. Instead, AHA uses "abdominal thrust."

By citing from the July 11-13 conference on first-aid standards that "abdominal thrusts" are "... hazardous, even lethal," Dr. Koop creates confusion among AHA-trained instructors who consider the abdominal thrust synonymous with the Heimlich maneuver. Terminology becomes quite important here; we equate the terms; now a distinction is being made and clarification is necessary.

Another question arises with chest thrusts that are now "hazardous." The AHA Student Manual (1) states "... because it is impossible to perform safe or effective abdominal thrusts on these victims (pregnant or obese), chest thrusts should be performed." What is recommended treatment for airway obstruction in the pregnant or obese if neither the abdominal thrust (Heimlich Maneuver) nor the chest thrust is advised?

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Reference.....

1. Student manual for life support. American Heart Association, 1981, p. 52.

Dr. Koop Responds

The success of a maneuver to dislodge a foreign body from the airway depends on a reservoir of air being forcibly expelled through the airway. The Heimlich Maneuver defines a specific action. "Chest thrusts" and

"abdominal thrusts" do not always convey the same specificity. Confusion can be avoided by teaching the mechanism involved.

As with any unusual situation (pregnancy, obesity), necessity is the author of invention, and an understanding of the mechanism rather than semantics should lead to alternate and hopefully successful actions.

In children there is no doubt that the American Academy of Pediatrics' position is correct. The accidental exclusion of the exception from the editorial was corrected in a press release.

*C. Everett Koop, MD, ScD
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What Is the PHS Goal for Sodium Levels?

In an effort to reduce the risk factor for hypertension, the U.S. Government has suggested that the average daily sodium ingestion (as measured by excretion) should be reduced at least to the 3-6-gram range (130-260 mmol), as reported in the September-October 1983 *Public Health Reports* supplement (1).

I am informed that the real intention was to set the 1990 goal at 3-6 grams of salt (50-100 mmol) (personal communications, J. M. McGinnis, 1985; R. Levy, 1985). I feel it would be valuable both within and outside the United States if the correct figure could be published in *Public Health Reports*. It may be worth mentioning that the Australian Recommended Dietary Intake (RDI) for sodium is 40-100 mmol per day (2).

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References.....

1. Public Health Service implementation plans for attaining the objectives for the nation. *Public Health Rep (Suppl.)* 98: 6-16, September-October 1983.
2. National Health and Medical Research Council: Report of the 93rd session: supplementary table of recommended dietary intakes. Australian Government Printing Service, Canberra, 1983.

Clarification of Sodium Figure Quoted in 1990 Objectives for the Nation

Dr. Beard is correct in noting that the "daily sodium ingestion" of 3-6 grams referred to in objective "b" of the High Blood Pressure Objectives and in objective "g" of the Nutrition Objectives is erroneously stated (Promoting Health/Preventing Disease: Objectives for the Nation, pages 7 and 75, respectively).

It should read "salt," not "sodium." Three to six grams of salt corresponds roughly to 1.2-2.4 grams sodium. Likewise, the baseline data cited should read 4-10 grams salt (or 1.6-4 grams sodium).