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FAQ frequently asked questions

What is being done in the clinic-Witten anesthesia for safety?
1. Specialist Standard
The standard for medical specialists will always be respected, we are not even there in person, always represents an experienced specialist in anesthesiology. With our representatives, we have been working together for years, one of the representatives has been treated Johannes Rau and Joschka Fischer.

2.Überwachungsgeräte
We hold more than the legally required provisions beyond monitoring technology. Ultra-modern softwaregeführte surveillance monitors are not only the two operating rooms, but in each of the 8 Aufwachraumplätze available. Through intelligent alarm management, there is tiered alarm sounds, the distinction between "minor disturbances" and acute hazards. Devices to silent alarm signals have been sold (Our thanks go to Ebay ...). Brand new, we have introduced the advanced cardiac monitoring. In both surgeries, all relevant cardiac arrhythmia (* 1) are automatically detected and a cardiac blood flow monitoring (* 2) is displayed alarm system. Each patient's room and recovery room are equipped it a nurse. Beside that, the monitoring is capitalized by us and the staff.
(Will Detected * 1) and alerted to cardiac arrest, ventricular fibrillation, chamber volleys, Kammercouplets, bigeminy, trigeminal, R on T phenomenon, VES, tachycardia, bradycardia, pacemaker failure.
(2:00) This is done by the state of the art ST-segment analysis, an ECG procedure. The ST range is altered in vascular, an early warning about a heart attack can be seen sooner.

3.Notfallequipment
We hold more than the legally required emergency provisions beyond technology. There are three cardioverter defibrillator for use at any time available, the equipment is regularly maintained and checked weekly by my staff. Two energy biphasic defibrillators is one (no rule), this Defibrillationstechnik showed in a recent study as a reflection in the treatment of ventricular fibrillation. In line with current recommendations is one of the devices even an AED (automatic external defibrillator, no regulation).
It is a non-invasive pacemaker available (no rule). Next to it is comprehensive emergency medical equipment, and to the mastery quite rare incidents available (possible Dandrolen for the treatment of malignant hyperthermia, chest tubes for pneumothorax, Zentralvenenkathether in heavy circulation problems, differentiated inotropic support by means of several perfusors, various special tubes and special laryngeal masks for the management of the difficult airway, Quicktrach the emergency access to the trachea, Trachlight system for fiberoptic intubation lichtgeführten, ...). A tangible at any time Emergency box enables mobile availability for further anesthesia work "anywhere" including oxygen, ventilator, suction, emergency drugs.
Dr. Thöns has with "the senior emergency physician in Germany" Professor Sefrin standards for pediatric emergency equipment published [Thöns M., Sefrin P: Long Equippments emergency medicine for the children of emergency. The emergency physician wrote in 2007] and with S. Müller a book on pediatric emergency medicine [Memorix pediatric emergency, Thieme, 2009].
Arista / Traumadex

Haemorrhage during operations are frequent complications. Remedy is a new generation of blood-feeding, based on the innovative MPH ® (Microporous Polysaccharide Hemospheres, Arista / Traumadex) technology. Within 1-2 minutes it comes to bleeding, even in diffuse or arterial spurting bleeding. The practice of hospital Witten stops in front of this "emergency powder" as the first surgical device in NRW for use at any time. "Safety is our top!".
* Hong MF, Dorian P. Update on advanced life support and resuscitation techniques. Curr Opin Cardiol. 2005 Jan; 20 (1) :1-6

4th Use of safer anesthetic drugs
There are almost always used drugs with extremely high therapeutic index (which is the dose difference between the dose that is necessary for the therapy and the dose that leads to the poisoning). Thus the principal drug used here does not even with 10-fold overdose to damage (just to sleep just a little longer).
There is no risk for the medication for the sometimes fatal anesthetic fever (malignant hyperthermia by anesthetic gases) and there is no risk for delayed onset of respiratory disorders in the routinely used anesthetic drugs. Very rarely are used in our anesthetic gases, such as when it did not succeed in an infusion needle to lay before the anesthesia.
In contrast, the hospitals are usually conducted with anesthesia anesthetic gases, this is also encouraged by the new statutory provisions for operating krankenhausambulanten (§ 115 SGB V). Anesthetic gases are at risk of malignant hyperthermia lead to more seizures, tremor after anesthesia, the frequency of nausea and vomiting, often leading to confusion after anesthesia conditions, more frequent and severe complications **** stun not only the patient but also all of the gases in Contact people who are coming with the same. Besides them, a teratogenic effect is attributed. For us, anesthetic gases in the routine patient care out. A few years ago we were outsiders with this setting, now is in my Fachgeibiet much debate about it *.
In children, we have for years been no 5prozentigen Glucose solutions to an operation that was recommended in 2007 by the appropriate professional society, including Dr. Thöns has published this **.
* Schwilden: In volatile anesthetics can be avoided - Pro. AINS 39 (2004) 220
** Thöns, Sefrin: glucose infusion solutions in emergency medicine. The emergency physician 23 (2007) 5
*** Sümpelmann R, Hollnberger H, Schmidt J, Strauss JM: Recommendations for perioperative infusion therapy in neonates, infants and young children. Anasth Intensivmed 47 (2006) 616-619
**** Myles PS: Avoidance of Nitrous Oxide for Patients undergoing major surgery. Anesthesiology 107 (2007) 221

5.Einsatz safer anesthetic techniques
Advanced anesthesia techniques are applied depending on the surgical procedure and the wishes of the patient.
General anesthesia are mostly carried out by means of the laryngeal mask, the risk of ingress of blood or other fluids into the lungs, the trachea through a breathing tube (endotracheal tube is sealed). Would be suitable in such a case, the alternative of a partial anesthesia procedure, is a spinal anesthesia, epidural anesthesia or other regional processes (eg foot block, plexus block, Bier-block).
The technology is complemented by apparategestützte monitoring. Default is AT LEAST twice the measurement of oxygen content in blood with a double security alert incl power failure protection, continuous monitoring of cardiac activity, the enlarged heart rhythm and heart blood flow

monitoring (ST-segment analysis) and the 3minütliche automatic measurement of blood pressure. If general anesthesia is always the carbon dioxide content of the exhalation monitored continuously (capnography). This process has increased the anesthetic safety by a factor of 10 (!) And gives early information about respiratory disorders (such as the Fehlintubation), asthma attacks, pulmonary embolism, shock states tinkles or simply when the breathing tube is kinked or slip out of the trachea. As simple and obvious as it sounds, so it is understandable that even today still suffer severe disabilities and patients in Germany die, because it is without these non-mandatory surveillance. Philosophy and ambition is for all of us, however, to detect incidents before the monitor tinkles ". This is possible only through constant attention and extensive experience. We are especially proud that our young people already mitreagieren again and again before the devices.

6.Risikofaktor "human error"
We are physicians 'infallible', we give you this impression in the public and themselves partially in front of us ...
On the other hand we know a long time that "human error" is up to 80% as the main cause of preventable anesthesia incidents [Cooper 78]. In the United States die annually between 44000-96000 people because of medical mistakes, which are far more people than traffic accidents or per year die of AIDS.
These are individual, in the personality of the individual interest "human factors" that define the quality narkoseärztlicher care in both positive and negative. Among the factors that can modify the performance of the anesthesiologist physiological condition, personality and personal adjustment, training and include experience, knowledge loss and communication skills and error culture [Kuhnigk 03]:
a) Physiological-being:
An approach to self-assessment of the mood IMSAFE concept (Illness, Medication, Stress, Alcohol, Fatigue, Eating is), developed originally in the air of self-assessment pilot.
Such self-assessment we conduct regular in the team where it goes, employees are sent home or entrusted with less responsible activities. We are a very young - fitter team.
By not using anesthetic gases, we will not mitbetäubt through the air in the operating room ".
b) personality / attitude:
Anesthesiologists are after a British study of intelligent, reserved, serious and tense, compared to GPs [Reeve 80], these are personality traits which are advantageous for complex risk activities. - No comment ....
In the personality structure but also lay error provocative settings, with "Gegengedanken should" be addressed:
Set the wrong idea of recommended core Gegengedanke
Inviolability "For sure nothing happened to me" "It can happen to me"
Anti-authority, "Do not tell me what I do," "Think of the recommended procedure, usually it's true"
Macho "I'll show you I can do everything" "is only rely on dumb luck, do a plan"
Impulsive "Do something, quick" think "First act, then"
Resigned, "What's that, I can do nothing" "There is always something that can help"
This approach, we have made the team appropriated.
c) training and experience:
Everyone is very clear that someone has a better command of activity, if he himself often performs - "Practice makes perfect". This was recently shown in large studies including medical activities [Slogoff 98] and led ultimately to the fact that today some procedures may be performed only by

physicians who can demonstrate a certain frequency in the implementation.
As a practicing anesthesiologist, you can not distribute the work over several shoulders (as in a large hospital department), the anesthesia is for a more personal if the practice is running well, you're in 'constant practice.
Since 1998, approximately 20,000 patients in our practice alone anesthetized druch Dr. Thöns (as of 10/07), Practice Partner Holger Müller mountains since 1992 for medical specialist anaesthesiology. We both have our training in the St. Mary's Hospital Witten (head physician Dr. Sommer) started here, the focus in the learning of practical skills. We were after a few months for the group call. The high percentage of practical work we achieved in less than three years required for the specialist maturity minimum number of anesthesia, in particular, we have already three times done so many children anesthetics which are necessary for the board certification examination (Our thanks for this is not only Dr. summer, but also its chief physician Dr. Kahramanoglu, Dr. Monday and Dr. Neveling). Also was conducted by an assistant of Dr. Thöns exchange, the use of children in intensive care in St. Mary's Hospital Witten (PD Medical Director Heller).
The other significant part of the Thöns training has been in the BG-Kliniken Bergmann Heil, Bochum (Prof. Zenz Dirketor completed). The focus of the training was here in addition to the pain (Prof. Zenz, the President of the German Society for Pain Therapy) is particularly in intensive care (Herzintensiv, trauma ICU) and the management of anesthesia for major options and seriously ill patients. For a long time he was divided in heart surgery, the heart transplant he has acted. "My thanks here is regarded by many colleagues who provided me with great patience and effort the major interventions of the discipline taught (Drs White, Mathei, Dertwinkel, stockings, thunder, Wiebalck, Schepanski, Prof. Tryba) and of course Prof. Zenz, the somehow still "my boss is". " Holger Müller mountains has the further substantial part of his training in the then Essen Alfried Krupp completed hospital. The Alfried Krupp Hospital has been chosen as the maximum care clinic several months ago as "Germany's patient friendly hospital".
d) Knowledge and losses:
Training for us is not only annoying professional duty (for a contract physician are 50 training units per year mandatory, otherwise there are less fees ...) but is one part out of interest continuously maintained, on the other hand we are because of our verifier always read to rely on current literature and . quote In particular, the verifier confronts us again with incidents that have stimulating reflection on the improvement of our own practice and the submissions and here already led to extensive risk minimization. Learning from mistakes!
e) Communication skills:
A key factor of the air disaster of Birgen Air-years ago was the failure of communication between the pilot and copilot, from a certain point, the two only talked past each other, it followed the crash. Today we know that the faulty communication as a contributing factor in 25-30% of serious incidents is under anesthesia [Arbous 01].
are examples of communication failures in the operating room as: "I speak during surgery with the anesthesiologist," ambiguities "it bleeds a little" or snub "why does the OP for so long."
A major advantage of the independent working is that you can choose its operators (or the other way his anesthesiologist). This implies firstly that it is a pleasant work together. Surely we can also remind colleagues where this was not so, but these colleagues are now working with other anesthesiologists ...
Other problems arise if the number of people involved grows (assistant - Physician - Medical Director ...) and responsibilities are unclear.
As part of the praxisambulanten manipulating the powers and responsibilities, and the "command

structure" with the staff are quite clear. The anesthetist for life, the surgeon for the operation. Moreover Thöns have personally participated in several training in communication skills and accordingly (Prof. Husebö, Prof. Heid).
Communication in emergency care - even with various auxiliaries and hierarchies - from the ambulance service also well known.
f) errors Culture
Not least, may be called a positive culture of errors. The realization that errors may occur, since even the first step to improvement.
Not punishment or warning are our frame of error events in the foreground, but the regular team meeting. Together, we look for ways to allow a (possible) error never occurs again and work out a common goal: to minimize possible error.

7.standardisierte processes
Standardized processes to reduce the error "human error". Everyone knows his job, everyone is familiar with the role and dominates them. Standardiesierte procedures were also defined in terms of quality.

8.Notfallmanagement
The 1-2 times annual emergency drill is standard in our practice, will now offer this as training for our technicians to be and this is backed by the medical association regularly Westfalen-Lippe certified with 6 points.
Dr. Thöns is still an active emergency medical (ambulance service of the city Witten), and therefore constantly in person trained in emergency medical techniques. Likewise, the assistant Claudia Only Rescue assistant and so far very firm .. in emergency medicine
All employees are fit in techniques of resuscitation, the airway management and the infusion technique.
The personal training is complemented by the legally required treatment plans.
Dr. Thöns is textbook author for a book on pediatric emergency medicine.

And what happened at home?
You may not leave our practice only if humanly with complications and need not be counted if you feel personally secure. There are always patients (parents) who still want to stay longer, that is for us no problem, stay as long as you want.
In the years of our establishment - led, despite constant presence on mobile phones - less than 14 calls to the operations to a query by patients. This was nausea (in one case was actually a one-day inpatient hospital stay is for infusion), problems with urination (here handed the telephone notice of the impending catheter system to bring everything back to life again) and light bleeding that the surgeon per home visit been mastered.
For now more than 20000 we were not on the urban emergency medical service (such as post-operative problems), dependent ...

1st Will I wake up again?
The widespread view that the state of sleep induced by anesthesia medication might persist permanently - so you no longer wake up - is not correct.
To a "Nichtwiedererwachen" - that is called a coma as a result of anesthesia, it may possibly come in very heavy anesthesia incidents with massive, prolonged lack of oxygen. Such terrible incidents

happen fortunately very rare. It is for example almost more likely to suffer accidents to a flight to Turkey than to suffer a mishap.
The answer to the question is: Yes, you will wake up again.
For Koch, Krier Buzello, Adams: Anesthesiology. Thieme 2001

2nd How often it comes to anesthesia incidents?
In recent publications from the U.S., the current anesthetic risk is shown to be 1:200,000. This is - statistically speaking - an anesthesia as safe as a flight to Turkey (remember: "Flying is the safest form of transport"). Unfortunately, we doctors demanded to speak with our patients about the "risk" before the operation. Following this logic a captain would welcome via airplane crashes and hijackings ... (Talk?)
The great fear of the anesthesia is still in its early years in our field. was in the 50s was the risk of anesthesia or at about 1:1000, so that almost everyone of bad anesthesia problems with friends / report from his environment. You will not know anyone who has suffered an "anesthetic incident" in the last few years, or knows someone who knows someone, ... the incident suffered an anesthetic.
from: http://www.airsafe.com/airline.htm

3rd What are the causes of anesthetic incidents?
In a study of anesthetic incidents of the years 1974 - 1988, it was found that 93% of these incidents by (our existing) monitoring anesthesia monitors could have been avoided. So the problem is not that a patient is bad, that problem is mainly the fact that this was not through inattention and lack of monitoring equipment detected in time. Currently in particular the factor "human error" as the main cause of preventable anesthesia incidents highest regard (see below). A recent work from Germany shows that the most common single reason the penetration of fluid into the airway (aspiration at the moment). This underlines once more the need that you have to come to a sober anesthesia!
From: Tinker et al: Role of monitoring devices in prevention of anesthetic mishaps: a closed claims analysis 71 (1989) 541
Madea, Dettmeyer: Medical claims and patient safety. German doctors Verlag 2007

4th If a child under anesthesia dangerous?
In principle seems to be a general anesthesia in children to be as safe as in adults. Only in very young children (infants), there are more "technical problems".

5th How can I increase my safety during surgery / anesthesia?
In particular, by six things:
Read the information sheet for anesthesia carefully and answer the particular health issues very diligently. They help me so, accurately assess your health and minimize unnecessary risks (eg allergies, diabetes, drug use ...)
Always observe them to eat before anesthesia either to drink or smoke. All this increases the amount of stomach acid. If it solves the anesthetic to a passage of stomach acid into the lungs, it hardly made a treatable severe lung inflammation.
Parents should therefore their children before the procedure very closely and consider dining or drinkable out of the reach of the child to be removed. Also on teeth brushing should be avoided before surgery in infants.
The incident is the most common anesthetic tumbling from the bed patient. In adults, we use after the operation if necessary bed rail. In children must be a constant companion of the child to stay in

bed and watch this (especially if the "Schlafsaft was given"). If you ever want to briefly leave the room, discuss this before any event with a sister or us.
Come WARM for anesthesia, cover in the preparation room too well. A recent study showed that wound infections can be reduced as of 1 / 3 *.
Make with the fact that your child is in the recovery room after anesthesia always connected to the Sauerstoffüberwachungsmontor. If irritation please alert a nurse comes (meaning himself).
Instruct us to go there for loose teeth (also milk teeth). This could end up in the lungs and they would have to be removed in a separate operation.
* Heuer: Prewarming - introduction to a method for preventing perioperative hypothermia. The anesthesiologist 38 (2003) 581

6th If a patient under anesthesia is not more risky than general anesthesia in a hospital?
In Germany there are strict rules for the technical equipment used for the induction of anesthesia. The rules for this so-called anesthesia workplace are of course in practice and clinic immediately and be followed by conscientious colleagues consistently. In particular, the continuous measurement of oxygen content in blood (pulse oximetry is a rule!), And the measurement of carbon dioxide in the exhaled air has led to a revolutionary safety benefits of the anesthesia medicine.
Beyond the legal requirements in addition to our practice - so it makes sense - additional monitoring equipment used routinely, or are present:
The continuous measurement of respiratory gases - especially carbon dioxide in the expired air is performed at every general anesthesia / general anesthesia .*
The ST-segment analysis for detection of cardiac blood flow (heart attack) and the advanced automatic heart rhythm analysis.
A pacemaker, and 2 cardioverter defibrillators (1 AED) for the treatment of ventricular fibrillation and other heart rhythm disorders is available.
Various special tubes and laryngeal mask to facilitate the special "difficult intubation".
One of the rules far beyond reproach of emergency drugs and infusions / central venous and specialty needles. For example, it announced on 6/11/2009 new recommendations for incidents during regional anesthesia. The necessary medicines and a special update of the emergency plan made praxisinternen still in the same week [People et al 2009].
For every patient is in a recovery room after surgery, surveillance monitor available. The recovery room and patient rooms are equipped with a nurse emergency call system *
* These two points (surveillance monitors) would have avoided 93% of the incidents from the above-cited study. But the temporary assignment of units of blood is only secured in the hospital. So are procedures in which donor blood must not be given for a suitable practice and should be performed in the hospital.
Koch, Krier Buzello, Adams: Anesthesiology. Thieme 2001
People T, Graf M, Gogarten W, Kessler P, Wulf H: Recommendations for lipid treatment in the intoxication with local anesthetics. Anaesthesia & Intensive Care Medicine 50 (2009) 698

7th Is the staffing in the hospital any better?
A standard anesthesia department of a medium sized hospital is about ¼ of specialists in anesthesiology, the other doctors are in the training.
In our practice, they are always experienced from a "specialist in anesthesiology anesthetic." The emergency management is very important in our practice and practiced at least 1-2 times a year in the entire team. Personally, we keep things fitt in emergency medicine through regular work as an

emergency physician (1 X per month).
In addition, we are in under 90 seconds the area next to the already present Operateuer (professional!) The following additional specialists available: surgeon, emergency physician with qualifications in the same house Dr. Sabbagh, Dr. Psonka, pediatrician - neighbor, Dr. Vrettos, cardiologist, neighbors, Drs Hagemeister / Idris / Iwe - gynecologist

8th Is not a part of anesthesia gentle for the body?
Both a partial anesthesia (so-called neuraxial anesthesia), as a general anesthesia are safe and gentle process, which do not differ in terms of the frequency of serious problems. For some groups of patients is a neuraxial anesthesia beneficial for other general anesthesia. In this case I will certainly offer you a better procedure for you.
If both are equivalent procedures in your operation, I recommend more for full / general anesthesia for the following reasons:
The major advantage of ambulatory anesthesia is the rapid dismissal may in the home environment. The duration of anesthesia is to control only the duration of anesthesia very precise, in part anesthesia there is a large spread of Medikamentenwirkdauer (from too short, much too long). When neuraxial anesthesia, there is basically the risk of very severe headache in the days following that can be possibly even a re-puncture is necessary. Here, the risk seems to be increased where it is observed after the procedure no bed rest.

9th What will he done against the soreness?
We use an anesthetic technique that is performed in addition to the gift of a sleeping pill with a high level of administering drugs strong painkiller. Interventions that will normally occur where increased wound pain accompanied by local anesthesia procedures (Wundinfiltrationen, penile root block, etc.) or the patient is still under anesthesia längerwirkendes a strong painkiller. If this is insufficient you will be given in the recovery room as required by either drugs or the underlying venous catheter or as a suppository. With the expected continuation of pain, we give you some pain medication with either directly, or you get an appropriate prescription. So you can treat the pain on their own good. Where appropriate, we stand and call the operator 24 hours a day, if necessary a home visit is made.

10th Will I have severe nausea?
The technique used by us hypnotics (propofol) acts in passing as "anti-emetic, protects against so sick. As "vomit" suspected anesthetic gases are used here only rarely. The risk of vomiting is therefore quite small. After anesthesia, all patients are asked in writing to their sensitivities, it is an anonymous statistical analysis. This resulted in an evaluation of the data from 2004 that less than 4% of Pateinten complained of nausea or vomiting in the recovery room. In the international literature will specify the frequency usually occurring nausea after anesthesia with 30% after general anesthesia *, **. after ENT surgery even by 53%
Other advantages of the "anesthesia through the vein" are:
1.angenehmes sleep and waking, positive dreams.
2.seltenere confusion conditions after anesthesia (Va children) **
3.kein risk of "malignant hyperthermia" = catastrophic incident anesthesia **
4.kein risk of fruit injury (By the way, not only for you but also for my staff) **
5.keine environmental pollution (greenhouse effect by anesthetic gases) **
6.weniger strong shivering after anesthesia
7th "no sleep of anesthesia doctor and Operateuer"

8th epilepsietypischen no EEG changes consistent with anesthetic gases
9th Less laryngeal spasm (laryngospasm) to Narksen **
10th Less pain after the anesthesia ***

If two consecutive short anesthesia dangerous?
No. E.g. accident victims is one for weeks (sometimes months) operated on several times and kept in the meantime under anesthesia. Consequential damage due to the anesthetic drugs were not described.

Can I be awake during anesthesia?
Trouble reports in the lay press have led to a significant concern. A wakefulness in anesthesia announces changes in the next cycle parameters to particular movements. Thus, a proper wakefulness under anesthesia only reserved for anesthesia with anesthetic techniques of the muscles (called muscle relaxation) is possible, because you do not move here can. We use an anesthetic technique that is performed in addition to the gift of a sleeping pill with a high level of administering drugs strong painkiller. On muscle relaxants, we do not almost complete. There is absolutely zero risk of waking it but with any anesthetic technique, although recent studies show that the problem is much more rare than even a few years ago: So is the risk currently estimated at one event per 15 000 anesthetics. The consequences in the sense of late psychological disorders were less frequent and less sustainable. The risk is increased for greater regular use of drugs or alcohol. Please discuss this honestly with us.
[Schraag, S: incidence and consequences of intraoperative awareness. The anesthesiologist 56 (2007) 1183]

Must I give up jewelry and nail polish / cosmetics?
Mandatory here to remove nose piercings and rings as possible. Nose piercings are often very loose and may reach the lungs, swelling of the fingers in rings can lead to constrictions. In order to protect the finger, the ring would be separated if necessary.
Cosmetics and nail polish hinder the "diagnostic gaze" of the anesthesia physician can recognize the skin color of a lack of oxygen. However, as surveillance monitors react much earlier, in some cases due to a "Entschminken" may be omitted.

Do I take out my false teeth before the anesthesia?
"Yes and no" - The removal of dentures are always cause for much discussion in the context of preliminary discussions.
It applies the following rules: All you can remove yourself from the patient's mouth should be removed before the anesthesia. Smaller dental prostheses, which could fall out must always be removed.
Prostheses, the patient himself in the mouth while sleeping can, we will remove a rule but not in anesthesia if the patient so wishes.
Here there are two important things to note:
Under anesthesia, it can (with very low risk) will damage the denture. Will be assumed no liability.
If the "third parties" interfere with the anesthesia, they are removed under general anesthesia.

What are the most frequently asked questions of the patient after surgery?
1st place: When does it start?
Answer - you are done.
Number 2: When can I eat / drink?
Answer: Immediately, if you are in the recovery room.

3rd place: When can I smoke again?
"Answer: Start but not more !..."
4: When can I go home?
"Answer: - Please refer to themselves only to ..."

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