To the Editor:—I read with interest the study by Jaber et al. and the accompanying editorial by Tantawy and Ehrenwerth regarding pressure-support ventilation (PSV). The Jaber study is noteworthy for documenting that the performance of PSV using modern anesthesia ventilators approaches the performance of an intensive care unit ventilator. The editorial correctly indicates that the testing was not performed under conditions of varying lung compliance and airflow resistance that influence the ventilation result obtained when using PSV. Nevertheless, PSV is most likely to find application in the operating room for patients who can be allowed to breathe spontaneously rather than for patients who present a significant ventilation challenge. The question of whether we need PSV in the operating room is germane to clinical practice and needs to be addressed from the perspective of the clinical indications and potential advantages for the anesthetized patient.

Pressure-support ventilation was developed in the intensive care unit to allow patients to breathe spontaneously while intubated for long periods of time and for patients who are in the process of weaning from ventilator support. The clinical indications for PSV in the intensive care unit are not relevant to the operating room. Indeed, for many years, spontaneous ventilation was not used commonly in the operating room because of the work of breathing imposed by the airway and breathing circuit, and the potential for respiratory compromise. The introduction of the laryngeal mask airway reintroduced spontaneous ventilation to anesthesia practice, and we have used this technique despite having learned in the intensive care unit that the work of breathing imposed by an artificial airway and breathing circuit limits the advantage of spontaneous ventilation. Fortunately, studies indicate that PSV can improve oxygenation and ventilation, and even reduce the work of breathing for anesthetized adult and pediatric patients when using a laryngeal mask airway. Using PSV in conjunction with a laryngeal mask airway may well extend the use of laryngeal mask airways to longer procedures as effective ventilation can be achieved.

The potential clinical impact of PSV in the operating room extends well beyond supporting patients with a laryngeal mask airway. During emergence from anesthesia, establishing consistent spontaneous ventilation is useful to help ensure that a patient will continue to breathe effectively after extubation. Concern for hypoventilation and slow elimination of anesthetic agents has been an impediment to using spontaneous ventilation during emergence. PSV will facilitate the use of spontaneous ventilation during emergence by reducing the work of breathing and improving minute ventilation and may lead to more rapid elimination of anesthetic vapors. Certainly, establishing a consistent pattern of regular spontaneous ventilation before extubation is desirable before removing an artificial airway and ventilatory support.

Spontaneous ventilation has other advantages over controlled ventilation that may be realized now that PSV is available in the operating room. The ability to assess anesthetic depth is enhanced when the rate, rhythm, and depth of breathing can be observed. Titration of anesthetic agents, most notably opioids, is also facilitated. The abnormal ventilation/perfusion ratios that can occur during controlled ventilation may be less likely to occur when supported spontaneous ventilation is used rather than controlled mechanical ventilation. There is even evidence to suggest that PSV set to provide continuous positive airway pressure or bilevel positive airway pressure can be used in awake patients to prevent atelectasis during the preoxygenation process. Finally, spontaneous ventilation offers the safety advantage of knowing that the patient will likely continue to breathe even if an artificial airway should become dislodged.

Pressure-support ventilation has the potential to significantly influence anesthetic practice in many ways. The Jaber study provides data to allow clinicians to use PSV with the confidence of knowing that it will perform similarly to PSV used in the intensive care unit. We should begin to learn about this new modality, selecting patients who are easy to ventilate, where the risk of using PSV is not significant. As we gain experience, the clinical indications and advantages in the operating room will become more obvious. I welcome this new tool and believe it will become widely used in anesthetic practice to facilitate emergence, titrate anesthetic drug administration, improve intraoperative gas exchange, and potentially enhance patient safety by making patients less reliant on an artificial airway and mechanical ventilator. The question of whether we need PSV in the operating room will only be answered definitively by using it. The Jaber study provides the information needed to use PSV in the operating room with confidence.

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(Accepted for publication May 8, 2007.)

In Reply.—We appreciate Dr. Feldman’s comments on our editorial. Before extubating patients in the operating room, the anesthesiologist typically evaluates the patient’s respiratory effort, tidal volume, and respiratory rate, as well as the patient’s oxygen saturation and carbon dioxide elimination. To compensate for the difficulties of breathing through an endotracheal tube and the breathing circuit, we frequently apply continuous positive airway pressure using the adjustable pressure-limiting valve on the anesthesia machine. Knowing that continuous positive airway pressure is functionally a combination of pressure-support ventilation and positive end-expiratory pressure, the level of support is typically minimal. If the level of support were significant, the patient could be falsely judged as ready for extubation. At the conclusion of the procedure, the adjustable pressure-limiting valve is usually fully opened so that the patient’s respiratory perfor-
Awareness in a Community-based Anesthesia Practice

To the Editor.—I read with interest the recent report by Pollard et al.\(^1\) on the incidence of awareness in a regional medical system in the United States. The incidence of awareness in their study was comparatively low at approximately 1 in 15,000. This is an order of magnitude less than numerous other large studies conducted in the United States and around the world (incidence around 1 in 1,000).\(^2,3\) The authors attribute this difference to “the anesthesia providers involved, the types of anesthetics chosen, and/or investigational bias.”\(^4\) I believe that their result may have been due, in part, to investigational biases of their own.

The authors did not define awareness in their report (awareness is often defined as ‘postoperative recall of intraoperative events’\(^5\)). They imply that the definition was ‘recall or possible recall’ but later mention that cases of dreaming may have been missed by their data collection method. Dreaming during anesthesia is a remarkably common phenomenon that is rarely indicative of awareness and should not be confused with it.\(^6\) In studies of incidence, the primary endpoint needs to be prospectively and precisely defined.

In addition, the authors did not ask their patients a direct question about awareness. They omitted the question used by researchers in all of the large studies with which they wish to compare their work\(^2,3\). ‘Can you remember anything in between these two periods (that is, between going to sleep and waking up)?’ Would a study on postoperative vomiting be valid if the patients were not asked ‘Did you vomit?’ Moerman et al.\(^7\) documented that patients are reluctant to report awareness without being questioned directly. In addition, in my routine use of this question in research and clinical practice, I have not found that it alarms patients.\(^8\) The omission of this question is a potent reason for the lower incidence of awareness reported in this study.

The authors comment on possible investigational bias in previous studies, without discussing it any further or addressing the potential for investigational bias of their own. One could make the case that the aim of previous studies was to detect every case of awareness that had occurred. One could also make the case that an internal quality assurance program such as the one described in this study may be designed to minimize the incidence of adverse events such as awareness. The authors did not describe the procedures for adjudication of awareness reports, impanel an independent endpoint adjudication committee (with members from outside their practice group), or provide a description or count of awareness reports that were rejected.\(^9\) Readers therefore cannot interpret for themselves the subjective reports of awareness. These factors together throw doubt on the accuracy of their awareness incidence.

In Reply.—We thank Dr. Feldman for his interesting remarks regarding our recent contribution to ANESTHESIOLOGY, which showed that for the five tested anesthesia ventilators, pressure-support ventilation (PSV) functioned correctly.\(^1\) Indeed, our laboratory study\(^1\) showed that regarding trigger sensitivity and the system’s ability to meet inspiratory flow during PSV, the most recent anesthesia ventilators have performances comparable to those of the modern intensive care unit ventilators. We agree with Dr. Feldman that PSV will facilitate the use of spontaneous breathing with both a laryngeal mask airway and an endotracheal tube. As stated in the discussion of our article\(^1\) and in the accompanying editorial by Tantawy and Ehrenwerth,\(^2\) the PSV mode may be used in the operating room in spontaneously breathing patients who are undergoing peripheral surgery more often during local–regional anesthesia combined with light sedation with a laryngeal mask airway\(^3\) or an endotracheal tube. However, our study\(^1\) only provides the information needed to use PSV in the operating room with confidence, and further clinical studies should now be conducted to better define the indications and settings of PSV during both local–regional and general anesthesia.

Correspondence

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Reference


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In the past 10 yr, Dr. Leslie has received support from Aspect Medical, Inc., Natick, Massachusetts, in the form of grants for research and travel; she has also received support from the American Society of Anesthesiologists for presentations at state society meetings.
A lower incidence of awareness may be expected in a community-based setting with relatively few patients at high risk of awareness, relatively few anesthesiologists or nurse-anesthetists in training, a relative abundance of patients who were not given neuromuscular blockers, and a protocolized anesthesia care plan that may have promoted more-than-sufficient general anesthesia. Unfortunately, Pollard et al. did not provide data about any of these potential confounding factors, and their methods cast doubt on their conclusion that the incidence of awareness is 1 in 15,000 in their practice.

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(Accepted for publication June 12, 2007.)
In Reply.—Thank you for the opportunity to respond to the letters by Dr. Leslie and by Dr. Sebel et al. We welcome the opportunity to clear up some misconceptions about our study that are put forward in those letters.

Dr. Leslie expressed concern that we had not defined awareness in our study. Dr. Brice et al.1 offered this definition: “awareness has been taken to mean the ability to recall, with or without prompting, any events which occurred during the period at which it was thought the patient was fully unconscious.” This has been an accepted definition for several decades and we, perhaps mistakenly, did not think it needed to be repeated.

Dr. Leslie and Dr. Sebel et al. expressed concerns over the questions used in the study. We used the questions designed to elicit awareness as defined by Dr. Brice in 1970.2 As was described in the article, we substituted two nonawareness questions with two anesthesia-related ones to increase sensitivity. Despite the correspondents’ assertions, it is nonsensical to suggest that this substitution would cause a greater than 10-fold decrease in the incidence of anesthesia recall. Dr. Sebel et al. themselves admit that there is no evidence that differing modifications of the Brice questions are any more or less effective at detecting awareness. We also believe that the correspondents are mistaken in their belief that direct questions are required to elicit recall. The use of nonthreatening questions has been previously advocated as a valid technique of eliciting the incidence of recall in patients,3,4 thus obviating the need for the “crucial” question. It is our clinical experience that patients respond more openly to indirect and nonthreatening questions. We would also like to mention that with two interviews, a follow-up survey on anesthesia experience, and heightened public awareness of this problem, we still have not heard of any other cases.

Dr. Leslie and Dr. Sebel et al. expressed some confusion with regard to the mention of dreaming in the study. It was not our intention to discuss the incidence or categorization of dreams in the article. The issue was only mentioned because an in-depth analysis of dreaming during anesthesia was not undertaken in the postoperative period.

Dr. Leslie and Dr. Sebel et al. expressed concern about our use of a quality assurance program to collect data on patients. This process attempts to collect data on all patients undergoing anesthesia. The continuous quality improvement team completes this evaluation tool and ensures that all questions are answered and documented at several points during the patients’ hospital stay. As was mentioned in the article, the validity of the quality assurance data are confirmed by an independent audit performed retrospectively, using a statistically significant sample size to ensure the accuracy of collected data. The article reports all cases and suspected cases uncovered for the study period. Readers can therefore examine the reported cases and make their own assessment as to whether possible cases of recall should have been included in this study. The article emphasizes that the purpose of such a program is to identify and remedy the causes of such instances through education and system process modification, not through obfuscation. Dr. Leslie is therefore correct in that a quality assurance program is designed to minimize the incidence of adverse events.

Dr. Sebel et al. question the robustness of the data. We would like to reiterate that the purpose of a quality assurance process is to identify and monitor adverse outcomes to decrease these incidences through education and systems processes modification. This study illustrates the ongoing institution of a quality assurance process in a hospital system where new locations are added as the anesthesia group expands its practice. The majority of the patients included in the study were from the level I trauma and tertiary referral hospital where the system originated. Here, the quality assurance system failed to capture less than 10% of all cases. This compares favorably with the study of Dr. Sebel et al.,5 where they were unable to complete 53% of their interviews on enrolled patients. If the correspondents are concerned about the loss of comparatively few data points in our study, what must this say about their own? After all, a quality assurance database strives to collect information on all patients, whereas a research database is under no such constraint. The general impression that we are left with is that the use of a passive research database using recruited patients does a disservice to those same patients we are charged to protect.

Dr. Leslie suggests that the lower incidence of intraoperative awareness demonstrated in this study is due to lower risk patients in a community-based setting. This assertion conveniently overlooks the fact that the primary site in the study is a level I trauma center and tertiary referral hospital serving a population of several million. It is possible, but very unlikely, that this is one of the nation’s busiest hospitals serving “not really sick” patients. The article discussed the fact that this hospital has a similar acuity, but a higher volume, than the three other teaching hospitals in North Carolina.

Dr. Leslie finishes by alleging that the study in question may have been influenced by investigational biases. Unlike the correspondents, none of the authors work for, or are compensated in any fashion by, a corporation that stands to make money from the data. Nor is there any intent or ability to sell or profit from the study. There have been multiple articles on the use of corporate funds to conduct research.6,7 Lexchin et al.6,7 goes as far as to state that systemic bias favors products that are made by the company funding the research. One could rephrase one of Dr. Leslie’s comments by saying that the aim of previous studies was to inflate the incidences of intraoperative awareness.

In summary, we understand that Dr. Leslie and Dr. Sebel et al. are concerned about the implications of the study; however, we believe that these data represent a true picture of anesthesia awareness in clinical practice. The use of an independently audited quality assurance program allows practitioners to rapidly identify flaws in anesthetic techniques and practices, and to make the appropriate changes to decrease their incidence.

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(Accepted for publication June 12, 2007.)
To the Editor:—I read with interest the case report by Dhonneur et al. describing their use of the Airtraq® laryngoscope (AL; Prodol Meditec S.A., Vizcaya, Spain) in morbidly obese patients undergoing emergency cesarean delivery. I congratulate these authors on the incorporation of this recently introduced intubating device into their practice. However, there is surprisingly little discussion of the actual AL in their article.

The AL is a disposable laryngoscope that allows viewing of the vocal cords without a straight line of sight from outside of the patient to the vocal cords. The AL light should be turned on approximately 1 min before use, to allow heating of the lens and to avoid fogging. The neck of the patient can be positioned in a neutral position. The curved blade is inserted in the center of the tongue. While looking through the viewer (or optional video), it is advanced further such that the epiglottis is identified, and the tip is placed into the vallecula. The handle is then lifted straight up to expose the vocal cords. The AL has a channel that is used to direct the tube through the vocal cords once visualization has been achieved. I have successfully used the AL, and one important difficulty that was not stated in the letter is that the tube may pass posteriorly as it leaves its guide, and further manipulation of the handle of the AL may be needed to allow the endotracheal tube to be successfully passed through the vocal cords.

An important issue not discussed by the authors is the challenge of obtaining proficiency while at the same time controlling cost. The manufacturer recommends two to four uses before use in a patient with a difficult intubation. As in all techniques for intubation, there is a learning curve. ALs cost approximately $80 each and cannot be reused. This could pose a large expense to train an entire department and then maintain skills. It could also be a major ongoing expense if used frequently. If skills could be obtained in a simulator, the AL could be an important asset if kept on the difficult airway cart as a backup technique, but not used regularly. Obtaining the AL was discussed by our equipment committee but was not thought to be cost-effective for training an entire department, which has more than 100 members. Dhonneur et al. stated that the anesthesiologists had “performed the clinical learning process with the AL” but did not describe what this was; this information would have been helpful.

The authors state that “There are only two validated airway devices allowing visualization of the glottis without alignment of oral and pharyngeal axes: the LMA CTrach (SEBAC, Pantin, France) and the AL.” This is not true; there are multiple such laryngoscopes now available. The Glide scope (Saturn Biomedical, Burnaby, British Columbia, Canada) is a nondisposable video laryngoscope that is easy to use and allows visualization of the vocal cords without alignment of the axes. The endotracheal tube is held in the right hand and can be manipulated independently from the laryngoscope. The first laryngoscope developed, which combined fiberoptic viewing with a curved rigid blade, was the Bullard laryngoscope (Circon ACMI, Stamford, CT).

The authors also stated that the Sellick maneuver was applied before induction; this would potentially be uncomfortable for the patient. The cricoid should be palpated before induction, but the actual cricoid pressure should not be applied until the patient is starting to fall asleep. It has been recommended to apply 10 N (1 kg) of pressure as the patient is falling asleep and increase to 30 N after the patient becomes unconscious.

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(Accepted for publication July 3, 2007.)
There seems to be an urgency to conquer the management of the difficult airway in obstetric cases, but is there a danger of losing the conventional and tested skills (e.g., use of a McCoy laryngoscope for the first case) while rushing to find a magic bullet? The conclusion of Dhonneur et al.1 to consider the AL as a primary airway management device for the difficult airway in emergency cesarean delivery is, in our opinion, premature and daring.

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Comparing the Airtraq® with the LMA CTrach™

To the Editor—I read with great interest the case report by Dhonneur et al.1 using the Airtraq® (King Systems, Noblesville, IN) optical laryngoscope after failed direct laryngoscopy in two patients requiring emergency cesarean delivery. Placing an Airtraq® (or any of the new video-laryngoscopes, e.g., GlideScope® [Verathon, Bothell, WA], McGrath® [LMA North America, San Diego, CA]) as a brief plan B after a failed direct laryngoscopy in obstetrics may be an evolving new standard of practice for an emergency cesarean delivery. However, comparing the Airtraq® intubation time with the LMA CTrach™ (LMA North America, San Diego, CA) intubation time (<1 min vs. 3 min) is not an entirely appropriate comparison.1 The CTrach time of 3 min includes establishing ventilation and removing the CTrach airway after intubation is confirmed.2 The ventilatory capacity of the CTrach is arguably equally important to its effectiveness as an intubation conduit during airway resuscitation.3 It is well known how quickly a term parturient can desaturate during laryngoscopy. The CTrach (like the intubating laryngeal mask airway) is an effective ventilatory device with ventilatory success rates of greater than 99%.2,3 If intubation is not successful, the presence of an effective airway can be lifesaving. The CTrach gives the operator time to optimize the laryngeal view and the patient’s physiologic parameters before attempting intubation.3,4 Liu et al.5 report a 99% first-pass intubation success in the 84% of patients whose larynx was seen on the CTrach monitor. In the remaining 16%, the CTrach functioned as an intubating laryngeal mask airway would, with corresponding intubation/ventilation success rates. Ventilation and oxygenation, not solely intubation, are the primary goals of effective airway resuscitation.

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Comparing the Airtraq® with the LMA CTrach™

In Reply—We read with interest the letters to the Editor regarding our case reports, published recently in ANESTHESIOLOGY, describing the use of the Airtraq® laryngoscope (AL) in morbidly obese parturients undergoing emergency cesarean delivery.1 We think that it is a privilege to have our reports reviewed by such experts in the field of airway management. In regard to Dr. Neustein’s comments, positioning the AL in a difficult airway management algorithm is the result of a long educational and clinical process conducted through an airway management teaching program began almost 5 yr ago with the validation of a predefined algorithm for the unexpected difficult airway in the operating room2 and then in prehospital conditions.3 We have been conducting for 3 yr in France the first national University Diploma of Airway Management program, and now this French teaching program has evolved into a European diploma, the EXCLAM (Excellence Level in Airway Management). In 2005, with the arrival on the French market of the LMA CTrach™ (CT; SEBAC, Pantin, France), we have implemented our algorithm built in case of the unexpected difficult airway, and finally 1 yr ago we incorporated one of the new generation of tracheal intubation devices that we call the “glottiscopes,” such as the AL (VYGON, Ecouen, France). Since we submitted our case report to ANESTHESIOLOGY, a third “glottiscope,” the AirwayScope (PENTAX, Strasbourg, France), has become available, and we had the opportunity of testing it. These “glottiscopes” are equipped with both video-endoscopic resources and a built-in channel (or tube) driving the endotracheal tube in regard to glottis aperture into the trachea. The AL and, more generally, the other “glottiscopes” are really different from the basic, although sexy-looking, video-laryngoscopes, such as the GlideScope® (VERATHON Medical, Strasbourg, France) or the McGrath® (LMA North America, San Diego, CA), that are efficient at improving the Cormack and Lehane score but do not systematically facilitate and shorten tracheal intubation in case of a difficult airway.

Of course, we are concerned with cost-effectiveness, and we agree that $80 is certainly too expensive for a single-use primary airway management device. However, we are sure that if the AL were sold for less than 10% of its actual price, we would not use the Macintosh laryngoscope anymore in potentially difficult airway patients such as morbidly obese patients. Almost all of the anesthesiologists in our department have completed their learning curve with the AL. All are experts in airway management, and our university hospital is now

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Dr. Goldman has received speaking honoraria from LMA North America, Inc., San Diego, California.
considered as an Excellence Center for teaching airway management. In addition to cadaver training and manikin workshops, physicians become involved in regularly updated programs on new techniques in airway management. Teaching clinical use of new airway devices to residents or visiting physicians is systematically supervised and filmed. Our teaching program has been funded mainly by the university and private sources coming from attendees participating in our diploma program. Because his English is of better quality than ours, we thank Dr. Neustein for his nice description of the AL and its use. Moreover, we accept his advice on how to apply the Sellick maneuver.

In response to Drs. Chandan and Sadashivaiah, early and recent reviews have identified airway management complications such as aspiration of gastric contents, failed tracheal intubation, esophageal intubation, and airway obstruction as associated with anesthesia-related maternal mortality in Western countries. Moreover, some reports have recognized morbid obesity as a worsening factor of airway management difficulty. We believe that airway protection against aspiration of gastric contents requires insertion of a cuffed tube into the trachea as quickly as possible. Any device improving the laryngoscopic view (specifically in morbidly obese patients) and allowing visual control of the endotracheal tube passing through the vocal cords may eliminate the risk of esophageal intubation and fatal airway obstruction. Therefore, the AL, which combines the abilities to (1) facilitate the glottis view, (2) control the transglottic passage of the tube, and (3) dramatically reduce the time (elapsing between loss of consciousness to inflation of the cuff) to securing the airway, is of major interest for emergency and particularly obstetric anesthesia. For these reasons, we placed the AL as a brief plan B after failed direct laryngoscopy in emergency cesarean delivery patients and proposed it as a primary airway management device when parturients showed predictable criteria for difficult intubation. Moreover, we observed that video-controlled emergency tracheal intubation with the AL helped the operator performing the Sellick maneuver to adapt external manipulations over the cricoid area to facilitate glottis access without releasing cricoid pressure intensity. This interesting adaptation of the Sellick maneuver is not possible with the Macintosh laryngoscope when the glottis view is poor. As already stated, almost all of the anesthesiologists in our department have completed their learning curve with the AL. We have placed more than 250 ALs. We are conducting a randomized study in the intensive care unit, and we have recently been involved in clinical trials evaluating the AL in anticipated difficult airway patients, including elective cesarean deliveries. Accepted manuscripts are ready to be edited. We are sure that our data (and those of others coming from different teams) will convince Drs. Chandan and Sadashivaiah that our positioning of the AL in a difficult airway algorithm is not ‘premature and daring’ but rather results from a long maturation (almost 2 yr of training and practice) and rational reflection on the optimal airway management strategy to apply in emergency obstetric situations. We believe that the AL is not a ‘magic bullet’ but just an efficient airway device to facilitate tracheal intubation of difficult airway parturients. We did not aim to conquer any market but rather propose a reasonable and efficient alternative to the Macintosh laryngoscope, which was proposed almost 50 yr ago. We are sure that Drs. Chandan and Sadashivaiah will find on PubMed (May through August 2007) some interesting articles describing the use of the AL in difficult airway patients.

We are aware of the magnificent works performed by Dr. Goldman et al. 1–6 and we share similar opinions with Liu et al. 7 We have been involved in the first clinical trials with the CT,8,9 and we are still working on the evolution of this wonderful device. More than 300 CTs have been placed at our University Hospital of Paris, and not only for clinical trials. We confirm that the CT is the most effective ventilatory device, and we have also demonstrated great tracheal intubation performance of the CT in normal8 and difficult airway patients.5 Unfortunately, we are not certain that emergency tracheal intubation with the CT may prevent the risk of aspiration in case of true gastric content, as in our emergency cesarean delivery patients. Indeed, time to securing the airway with the CT requires, in expert hands, 1.5–2 min without real protection of the airway. First, the Sellick maneuver must be resumed during CT insertion. Second, maneuvers performed just after CT insertion to adjust ventilation (requested in 30–40% of cases) augment the risk of gastric inflation and increase pressure and regurgitation. Finally, the most risky period during CT manipulations occurs when maneuvers performed to optimize the view (requested in 50–60% of cases) require large-amplitude up-and-down movements of the mask. During these maneuvers, the distal tip of the mask is necessarily removed from its ‘protective’ place in the hypopharynx and exposes the airway to possible regurgitated contents from the stomach. For all of these reasons, we placed the CT in plan C for emergency situations in case of failure of the AL to intubate within 1 min and in plan B in case of poor oxygenation during airway management for any elective or emergency cases. Finally, we believe that the AL is the airway of choice in the situation of difficult direct laryngoscopy when there is urgency to secure the airway with a cuffed endotracheal tube, as in emergency obstetric situations.

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Decreased Alveolar Fibrinolysis in Patients with Ventilator-associated Pneumonia: A Species-specific Event

To the Editor.—In a recent issue of Anesthesiology, Song et al.¹ examined the relation between plasminogen activator inhibitor 1 (PAI-1) in bronchoalveolar fluid and mortality in patients with ventilator-associated pneumonia (VAP) caused by Pseudomonas aeruginosa. Although the authors found no difference in the concentration of PAI-1 levels between patients with VAP and those without VAP, there was a positive correlation between the levels of PAI-1 and the risk of mortality. Whether P. aeruginosa was responsible for more severe derangement in the fibrinolytic system compared with other VAP-responsive pathogens was hitherto unknown.

In a recent investigation, we demonstrated a bacteria-specific activation of the tissue factor–dependent procoagulant system.² Our observations paralleled those of Song et al. in documenting a profound shift toward procoagulant activity when P. aeruginosa was the culprit. Infection with methicillin-sensitive Staphylococcus aureus, methicillin-resistant S. aureus, and Escherichia coli induced similar coagulation imbalance, but the derangement was less severe in terms of intraalveolar fibrin deposition. More importantly, the restoration of the hemostatic balance was delayed in cases of P. aeruginosa VAP despite adequate antimicrobial therapy. However, the study did not assess the role of PAI-1 as a function of bacterial pathogens. Therefore, to evaluate whether the observed coagulation derangement may be due to species-specific inhibition of fibrinolysis, we tested our bronchoalveolar lavage samples collected at the onset of VAP and at day 4 and day 8 after treatment for PAI-1 levels. Figure 1 shows that PAI-1 levels were elevated for all pathogens at the onset of VAP compared with controls (C). *P < 0.05 compared with controls. †P < 0.05 compared with MRSA. Analysis of variance results among the four groups for days 0, 4, and 8 are 0.04, 0.02, and 0.002, respectively.

It is clear that the derangement of the local alveolar coagulation system seems to be a universal reaction to invading pathogens, but whether local and/or systemic intervention aiming at preventing local alveolar fibrin deposition can translate into improved outcome remains an unanswered question.

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(Accepted for publication July 6, 2007.)

Possible Mechanisms Underlying the Effects of Inhaled Nitric Oxide

To the Editor.—We read with great interest the recent elegant and important article by Mathru et al.,¹ who demonstrated that inhaled nitric oxide attenuates reperfusion injury and inflammatory responses in humans. We would like to add a few comments regarding the possible mechanisms underlying these exciting effects of inhaled nitric oxide.

First, ischemia–reperfusion injury is characterized, in part, by increased tissue oxidative stress, i.e., the formation of reactive oxygen species, including superoxide.² Nicotinic adenine dinucleotide phosphate (NADPH) oxidase has emerged as a major inducible source of superoxide.² In turn, NADPH oxidase expression and activity is rapidly up-regulated by factors associated with ischemia–reperfusion injury. These include hypoxia, cy-
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To the Editor—The Prevention by Epidural Injection of Postherpetic Neuralgia in the Elderly study recently showed that a single epidural injection of local anesthetics and steroids during the acute phase of herpetic zoster was not effective for the prevention of long-term postherpetic neuralgia compared with care as usual. However, it was associated with a modest but significant effect in reducing the presence of pain (relative risk, 0.83; 95% confidence interval, 0.71–0.97) and severity of zoster-associated pain at 1 month after injection (median visual analog scale score in the epidural injection group, 2 mm [25th–75th percentiles, 0–25] vs. 6 mm [0–32] in the control group). Here, we report the economic analysis of the Prevention by Epidural Injection of Postherpetic Neuralgia in the Elderly study to assess the balance between the additional costs of a single epidural injection and the associated benefits.

The Prevention by Epidural Injection of Postherpetic Neuralgia in the Elderly study included 598 patients older than 50 yr with acute herpetic zoster (rash <7 days) below dermatome C6. All patients received the current herpes zoster standard treatment, i.e., analgesics and antiviral medication (if rash <72 h). Patients randomly allocated to the intervention group in addition received an epidural injection of bupivacaine and steroids.

Quality of life was assessed using the EQ-5D at various time points: at inclusion and at 1, 3, and 6 months after inclusion. The EQ-5D is a generic measure that defines health-related quality of life in five dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Cost data about units of resource utilization (including doctor visits, medication, additional visits to healthcare providers, and hospitalizations) were also collected. All costs were estimated from a societal viewpoint. Costs of the epidural injection were estimated using two approaches: (1) the actual costs (€186) defined by the sum of labor (32 min by an anesthesiologist, 36 min by a nurse, and 20 min by an administrative employee), costs of material and location (€40), and overhead (€46); and (2) the current charges for an epidural injection (€870) as defined by the recent diagnosis-therapy-combination reimbursement scheme adopted by Dutch medical insurance companies. All other costs were estimated using tariffs. Direct non-healthcare costs included costs of paid and unpaid help. Indirect costs of loss of production owing to absenteeism from work or days of inactivity were not included, because most study participants were retired.

All analyses were performed with an intention-to-treat approach. The balance between costs and effects was expressed in terms of additional costs per additional quality-adjusted life year (QALY). One QALY equals 1 yr of full-health life. QALYs were calculated using the York A1 tariff. Because the estimate of the costs highly depended on the chosen cost estimate of the epidural injection, we assessed to what extent the results and inferences from our analysis were determined by the chosen cost estimate.

The EQ-5D scores at 1 month significantly differed between both treatment groups. From 3 months onward, however, these differences lost statistical significance. The number of QALYs in the intervention group was 0.412 (SE = 0.006), and that in the control group was 0.403 (SE = 0.005). This leads to an estimated difference of 0.010 QALYs (95% confidence interval, −0.006 to 0.026). After 6 months, the estimated difference in total costs with and without epidural injection—excluding the cost of the injection—was estimated at €6. When the costs of the injection were estimated at €186 (based on resource

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Cost Effectiveness of Epidural Injection of Steroids and Local Anesthetics for Relief of Zoster-associated Pain

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75th percentiles, 0 –23
Complications such as meningitis and epidural abscess may induce additional costs and reduction of quality of life. Assuming an adverse event risk of 1:10,000 and estimating the associated costs at €10,000, the costs of the injection increase with €1. Similarly, a major loss of QALYs caused by complications (e.g., 20) may only slightly decrease the gain of effectiveness (i.e., 20/10,000). Therefore, allowing for the small risk of severe complications does not substantially disrupt the estimated balance between costs and effects of the intervention. Second, the results of the Prevention by Epidural Injection of Postherpetic Neuralgia in the Elderly study do not rule out that the observed short-term analgesic effect by the epidural injection could as well be achieved by adequately administered, and possibly less costly, oral analgesics.

In conclusion, an epidural injection with steroids and local anesthetics modestly relieves the acute pain in older zoster patients with an acceptable balance between actual costs and effects as compared with standard treatment. The balance may tip to the other side, however, when the local tariff for epidural injection is much higher than the actual costs.

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To the Editor:—Anesthetic procedures are performed regularly in survivors of the 1930s poliomyelitis epidemic, some of whom may have developed postpolio syndrome.1 When a patient with postpolio syndrome is scheduled to undergo a procedure requiring anesthesia, anesthesiologists should carefully assess the patient’s preoperative status, namely his or her respiratory function, and inquire about swallowing difficulties or history of intolerance to any general or local anesthetic agent. The use of neuromuscular blocking agents in this context remains controversial.1 Increased potency of nondepolarizing neuromuscular blocking agents occurring in patients with a history of poliomyelitis has been suggested.2 It is also traditionally well accepted that succinylcholine should be avoided in patients with neuromuscular disease to prevent fatal hyperkalemia. Interestingly, however, this assumption has not been based on any specific report regarding the use of succinylcholine in the context of postpolio syndrome.1 Hence, we report here the first case of successful use of succinylcholine in a patient with postpolio syndrome who underwent elective cesarean delivery during general anesthesia.

A 39-year-old woman (height, 150 cm; weight, 65 kg) was scheduled to undergo elective cesarean delivery at 38 weeks of amenorrhea. She presented with postpolio syndrome according to all of the criteria of Mulder et al.:3 a history of paralytic poliomyelitis when she was 1 yr old followed by motoneuron deficit with electromyographic confor-
tion. She then had a 20-yr period of recovery and functional stability before experiencing gradual and major peripheral muscular fatigue with muscle atrophy of the limbs starting 5 yr ago, for which no other diagnosis was proved. The patient’s motor deficit due to polio at that time was isolated paraplegia without respiratory or bulbar weakness. She presented with atrophy and motor deficit of the limbs. She had no respiratory problems, thoracic deformation, or sleep apnea. Her medical history showed a comprised cholecystectomy performed during general anesthesia 25 yr ago, but no information regarding the type of anesthetic agents used was available. Preoperative evaluation showed the absence of criteria predicting difficult intubation. The blood potassium level was 3.4 mM. General anesthesia, versus spinal or epidural anesthesia, was chosen after an extensive risk–benefit discussion for a central nervous disease, which could have been a relative contraindication to the use of succinylcholine and hence to general anesthesia. However, the patient declined fiberoptic tracheal intubation and gave informed consent for general anesthesia with orotracheal intubation. Succinylcholine was therefore chosen because of the lack of absolute contraindication to this agent in the current case and the patient’s full stomach. After a 10-h fasting interval and preoperative medication with oral effervescent cimetidine (400 mg), preoxygenation was performed for 5 min. Anesthesia was induced with propofol (150 mg in 30 s); a reference train-of-four ratio was measured showing four motor responses at the adductor pollicis. Succinylcholine (50 mg) was then given, and the trachea was intubated 1 min later under the Sellick maneuver, with excellent conditions of exposure of the larynx and no response to train-of-four stimulation. Tympanic temperature was recorded every 15 min and kept as close as possible to 37°C by keeping the patient covered with a Bair-Hugger warming blanket (Arizant France, La Ciotat, France) throughout the procedure. Anesthesia was maintained with use of isoflurane (0.6% end-tidal), nitrous oxide (50%/50% in oxygen, vol/vol), and 0.15 μg/kg sufentanil after extraction of the newborn to obtain a Bispectral Index value between 40 and 60. The Apgar score was 9 at 1 min and 10 at 5 min after delivery. Because of the long-acting effect of succinylcholine, no additional injection of a nondepolarizing neuromuscular blocking drug was required despite the long duration of surgery (90 min). The train-of-four measured at the adductor pollicis every 5 min showed full recovery of the four motor responses only 35 min after tracheal intubation. The trachea was extubated uneventfully shortly after skin closure. The patient was transferred to the postanesthesia care unit. Postoperative pain was treated with use of paracetamol, nefopam, nonsteroidal antiinflammatory drugs, and intravenous morphine titration. Only 6 mg intravenous morphine was required on postoperative day 1. Neurologic examination was performed daily from postoperative day 1 to day 5 and did not reveal any abnormal drowsiness, myalgia, or other significant change in comparison with the patient’s preoperative status. The full postoperative course was uneventful, and the patient was discharged from the hospital on postoperative day 5.

Our case is the first report demonstrating that succinylcholine may be used safely in patients with postpolio syndrome. In the current case, the choice of general anesthesia with succinylcholine was based on an extensive risk–benefit analysis with discussion of general anesthesia and perimacular anesthesia. A lack of symptoms suggesting a diagnosis of postpolio-related central disorder syndrome, a normal preoperative blood potassium level (although of limited value in predicting the magnitude of potassium increase due to motor endplate receptor up-regulation), a full stomach with an increased risk of pulmonary aspiration, and a possible harmful effect on residual motoneurons of the limbs due to local anesthetics given by intrathalcal injection were the cornerstones to support our decision. One may notice that the dose of succinylcholine that was used (0.8 mg/kg) resulted in a prolonged depolarizing action on the train-of-four. We do not believe that hypothermia played a role in this case, because great attention was paid to keeping the patient warm during the procedure. We suggest that, more likely, sensitivity to succinylcholine (and probably muscle relaxants) is enhanced in patients with postpolio syndrome, necessitating careful titration and monitoring of muscle relaxants in this context. The prevalence of postpolio syndrome is estimated to be in the hundreds of thousands in the United States. Overall, we hope that our data will provide useful information for anesthesiologists in their clinical practice.

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