To the Editor—I read with great interest the recent report by Shore-Lesserson and Reich\(^1\) detailing diffuse venous thromboembolism in the setting of aprotinin and adult deep hypothermic circulatory arrest. To my knowledge, this is the first reported case of venous thromboembolism associated with aprotinin and adult deep hypothermic circulatory arrest in the era of adequate heparinization, as defined by standard-of-care activated clotting time and heparin levels. This case report adds to the recent reports of arterial thrombosis (both pulmonary and systemic) associated with aprotinin in adult cardiac surgery with or without deep hypothermic circulatory arrest.\(^2\)–\(^4\)

Therefore, significant life-threatening thrombosis is possible throughout the cardiovascular system during complex cardiac surgery in the setting of aprotinin, despite standard-of-care heparinization. It seems to be uncommon, as evidenced by randomized controlled trials.\(^5\)

Conceptually, periparoperative vascular thrombosis could cause mortality in the intraoperative or postoperative period. The case reports describe intraoperative death in this scenario.\(^1\)–\(^3\) The possibility of death and/or serious morbidity in the postoperative period from vascular thrombosis associated with aprotinin has recently been raised.\(^6\)–\(^7\)

Massive vascular thrombosis associated with aprotinin in complex cardiac surgery is rare, but real and catastrophic. The common factor in all the case reports is the onset during or shortly after heparin reversal with protamine, heralded by hemodynamic collapse and ventricular failure.\(^1\)–\(^5\) There may or may not be an identified prothrombotic risk factor including factor V Leiden.\(^1\) Clearly, there is a net prothrombotic effect achieved during or after heparin reversal, triggering disseminated major acute intravascular thrombus. On the basis of the existing reports, further clarification of the mechanism is conjecture. However, it is also clear that this phenomenon is not only possible with aprotinin but also with aminocaproic acid.\(^4\)–\(^8\)

In complex cardiac surgery, pharmacologic dampening of fibrinolysis reduces allogeneic transfusion and mediastinal reexploration for bleeding, an independent predictor for perioperative mortality.\(^9\) There is, however, a small but important risk of catastrophic cardiovascular thrombosis in the setting of antifibrinolytic exposure, despite standard-of-care anticoagulation with heparin (monitored by activated clotting time and/or heparin level).

How do we balance these risks? Should the criteria for heparin-based anticoagulation be refined? If so, how and based on what evidence? What about the role of possible concomitant antithrombin deficiency?\(^10\) Should patients be screened for underlying procoagulant conditions such as factor V Leiden?\(^3\)–\(^8\),\(^11\) How are all of these considerations modified in the presence of direct thrombin inhibitors, given their arrival as alternatives to heparin for clinical anticoagulation and reversal with protamine, heralded by hemodynamic collapse and ventricular failure?\(^1\) Anesthetic and surgical patient with factor V Leiden. ANESTHESIOLOGY 2006; 105:219–21


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To the Editor:—We read with great interest the report of Shore-Lesserson and Reich1 regarding a fatal case of venous thromboembolism during cardiac surgery with hypothermic circulatory arrest associated with the use of aprotinin in a patient diagnosed, with postmortem analysis, as a carrier of factor V Leiden. The same authors had previously described two fatal cases of intraoperative thrombosis in patients undergoing the same surgical procedure and treated with α-aminocaproic acid: One of the two patients was a postmortem-diagnosed carrier of the factor V Leiden mutation.2 Because of the occurrence over a 3-yr period of four fatal thrombotic events in cardiovascular patients operated on with hypothermic circulatory arrest and treated with antifibrinolytic drugs, the authors of these reports are now screening for the factor V Leiden mutation all patients scheduled to undergo elective surgical procedures requiring hypothermic circulatory arrest to avoid the use of antifibrinolytic drugs in patients who are carriers of the mutation. It has been proposed to classify the major hereditary prothrombotic conditions in two major groups, including hereditary deficiencies of natural anticoagulants and hereditary disorders associated with increased function of coagulation factors.3 The factor V Leiden mutation, which renders activated factor V resistant to proteolysis by activated protein C, belongs to the second group of inherited prothrombotic conditions and is frequently observed in white but not in Asian or African people.4 Whereas many subjects with deficiency of natural anticoagulants experience venous thromboembolism before the age of 60 yr, only a minority of factor V Leiden carriers will ever develop thromboembolic events.5 If factor V Leiden plays a contributory role in the development of intraoperative thrombosis in patients undergoing cardiac surgery with hypothermic circulatory arrest and receiving antifibrinolytic drugs, then patients with deficiency of natural anticoagulants should be at even greater risk, also given the effect of hemodilution. In addition, screening for the prothrombin G20210A mutation should also be recommended, because the associated hyperprothrombinemia has been shown to inhibit plasma fibrinolysis through a TAFI-mediated mechanism.6 The sheer volume of cardiac surgical procedures that are performed (Accepted for publication November 15, 2006.)

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In Reply—We are pleased to respond to the comments that address our case report “A Case of Severe Diffuse Venous Thromboembolism Associated with Aprotinin and Hypothermic Circulatory Arrest in a Cardiac Surgical Patient with Factor V Leiden.”4 We agree with Dr. Augoustides that thrombosis after cardiac surgery is a rare event, yet often fatal. When it is reported, it is temporally related to the reversal of heparin with protamine, presumably because the anticoagulant effect of heparin therapy is being neutralized and thus any “protective” effect from thrombosis is removed. Dr. Augoustides’ suggestion that this may be the first report of venous thrombosis in association with antifibrinolytic therapy is true with respect to the published literature; however, we know this complication to be dramatically underreported. Furthermore, it remains to be proven that thrombosis of the pulmonary artery is truly “arterial” pathology. Often, this complication is the result of venous thromboembolic phenomena that present as pulmonary thromboembolism. The sheer volume of cardiac surgical procedures that are performed using antifibrinolytic therapeutic agents where no occult thrombosis occurs, further affirms the hypothesis put forth. That is, when life-threatening thrombosis occurs in association with cardiac surgery and

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antifibrinolytic therapy, there should be some other hypercoagulable predisposition responsible for tipping the balance in favor of thrombosis. This delicate balance between bleeding and thrombosis is steadied by procoagulant factors, anticoagulant factors, fibrinolysis, and platelet-related factors. Many of these previously undiagnosed adverse thrombotic outcomes are now prospectively being identified as hepatic-included thromboembolopatety type 2, as a result of better diagnostic techniques. This addresses Dr. Augoustides’ question regarding the use of direct thrombin inhibitors. We would agree that better suppression of thrombin formation coupled with the avoidance of heparin would reduce the occurrence of many of these adverse thrombotic events. The suggestion for an international registry for reporting of thrombotic events is commendable and would be supported by us. An international registry for deep hypothermia and circulatory arrest is also currently under investigation.

We also embrace the comments of Dr. Casati et al. in that they have also suggested a registry for the reporting of adverse thrombotic events. However, we do continue to support the screening of elective deep hypothermia and circulatory arrest patients in our institution. This represents a very small subset of cardiac surgical patients at any institution. The cost is therefore not prohibitive, and the accuracy of testing is extremely high. Both the factor V Leiden mutation and the prothrombin mutation G20210A occur with a prevalence of 1–8% in the European population and are even less prevalent in Asian and African-American persons. Therefore, the number of patients identified as positive will be small. Donahue et al. have shown that patients with factor V Leiden can undergo cardiopulmonary bypass safely even with the use of antifibrinolytic drugs. In fact, these patients have less bleeding and may not need the benefit of antifibrinolytic agents, irrespective of the safety of this practice. Therefore, the question arises: Is a patient with a genetic predisposition to hypercoagulability one that would be considered to benefit from the use of antifibrinolytic agents?

Dr. Casati et al. suggest that patients with a deficiency of anticoagulant activity would be at greater risk than those with an excess of procoagulant activity due to hemodilution. We do not necessarily agree with this conclusion and think that it is difficult to conjecture which groups of patients would be at highest risk for thrombosis. The hemostasis system is rich with feedback mechanisms and protective pathways that act as fail-safe mechanisms to ensure normal clotting. When a patient has excess thrombotic activity, it is the fibrinolysis system that acts to restore the balance. If fibrinolysis is inhibited, coagulation can proceed unchecked. However, a patient with deficient fibrinolysis (such as PAI-1 excess or the prothrombin mutation G20210A) already has ineffective fibrinolysis and thus relies on other functional anticoagulant pathways that are not pharmacologically inhibited to restore the balance. In cardiac surgical patients where the perturbations of the hemostasis system are extreme, we support that patients with a history of hypercoagulability should be screened so that appropriate hematologic management can be instituted.

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In Reply.—We thank Dr. Neustein for his comments and appreciate the opportunity to reply.

We agree with Dr. Neustein that the absence of reliable data on airway pressures and tidal volumes during one-lung ventilation is a major limitation of our study. Indeed, we are currently undertaking a prospective cohort study in patients at high risk for postoperative pulmonary complications such as those undergoing lung resection to evaluate the cumulative exposure to potentially harmful intraoperative ventilator settings. This study includes a precise calculation of exposure during one-lung ventilation.

Our study design did not allow us to determine the mechanism of the observed interaction between the intraoperative tidal volume and fluid administration.1

A definitive trial to prove that intraoperative mechanical ventilation per se causes acute lung injury in humans would be difficult to design. Short-term large tidal volume mechanical ventilation during anesthesia has been associated with worsening pulmonary inflammatory response in experimental animal models.2,3 Despite some controversies, corresponding human data support the hypothesis that even brief exposure to high-tidal-volume ventilation influences the inflammatory and coagulation response in the lung.4–6 In our study, postoperative respiratory failure in the group of patients receiving larger tidal volume was observed during surgery as short as 244 min (25% interquartile range). Although optimal ventilator settings in patients undergoing pneumonectomy are yet to be determined, we believe that to maximize patient safety, routine use of very large tidal volumes (>10 ml/kg predicted body weight) during two- and in particular during one-lung ventilation is potentially harmful and should be avoided.7–9

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**Therapy in Postpuncture Meningitis**

To the Editor.—We read with great interest the comprehensive overview by Baer4 regarding post–dural puncture (bacterial) meningitis (PDPM). However, some questions can be raised regarding treatment for Health Research and Development (ZonMw), Den Haag, The Netherlands, and a personal grant from The Netherlands Organisation, Rotterdam, Minnesota. fernandez.evans@mayo.edu

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To the Editor:—I read the articles “Post–Dural Puncture Bacterial Meningitis”1 and “Incidence of Epidural Hematoma. Infection, Neurologic Injury in Obstetric Patients with Epidural Analgesia/Anesthesia”2 and the editorial “Gloved and Masked—Will Gowns Be Next? The Role of Asepsis during Neuraxial Instrumentation”3 in the August 2006 issue of ANESTHESIOLOGY. They are very informative with many excellent areas of discussion. However, it seems to me that there is one glaringly large area that was missed in all three articles. The issue is the source of contamination of the epidural space. It makes me shudder to see anesthesiologists inject room air, which may have a droplet from any of a dozen people’s noses who have been in the room in the past hour! Many residents, not sure of the feel, will then inject several more milliliters. Then they wonder why they have a spotty block! But that is another issue. In my opinion, injecting air should have been clearly condemned, but it was not even mentioned. Three of the four deaths presented had multiple epidural attempts, at least some with inexperienced personnel. How many cubic centimeters of air were injected? Maybe the source of infection results from the combination of air plus a dural puncture. Was there an epidural attempt before the obstetric spinal case? The only thing that should be injected into the epidural space is sterile liquid that is filtered for glass. Preferring the feel of the space is sterile liquid that is filtered for glass. Preferring the feel of the

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Think about Room Air

Rather than go through the inconvenience of learning the feel of the saline method, those practitioners continue to subject the patient to the risk of infection. This ban should include the hanging drop method. Although less air is entrailed, why allow any? It seems clear that the data show that room air has contaminated droplets and that injecting them into the epidural space is unnecessary and of greater risk than using saline. Of even more concern is how many other issues are out there, easily discovered, if we only followed up with our patients and accurately measured outcomes as we are morally obligated to, but rarely, do.

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(Accepted for publication December 8, 2006.)

To the Editor:—The editorial “Gloved and Masked—Will Gowns Be Next?” by Hepner3 is both interesting and disconcerting. The main reason surgeons resist neuraxial anesthesia is because “It takes too long!” For this reason, it is frightening to see the rubric “Will gowns be next?” Demanding that anesthesiologists wear gowns to perform neuraxial anesthesia will, in my opinion, be the death knell for spinal and epidural anesthesia. Locating and donning a gown for these procedures will obviously not make doing them less time-consuming. More importantly, is it even necessary?

Despite outcome data demonstrating a 1:10,000 to 1:50,000 risk of post–dural puncture meningitis, Dr. Hepner bases his recommendations for using gowns during neuraxial anesthesia on logic: “we must

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Parturients Expect Safe and Clean Regional Anesthesia

To the Editor—The largest single group of patients receiving central blockades worldwide is undoubtedly parturients. Fortunately, serious complications are rare, as pointed out in two recent studies published in Anesthesiology.1,2

Ruppen et al. found six epidural hematomas and justly considered these numbers inadequate to produce a robust estimate of event rates. Because of their study design, several cases reported in the literature are excluded from the statistical calculation performed in the meta-analysis. For example, the Closed Claims project included three spinal hematomas in obstetric patients.3 Many other excluded cases occurred in patients with impaired coagulation due to preeclampsia or large blood loss, conditions that might predispose even to a spontaneous spinal hematoma.4–6 Nonetheless, despite frequent bloody taps and thrombocytopenia, spinal hematoma is rare in obstetric patients.7,8

The compliant spinal canal in a young individual permits the introduction of volumes that may cause severe symptoms and permanent damage in an older person with a stenotic spinal canal.

However, a healthy parturient receiving epidural blockade for pain relief might overnight turn into a patient with severe coagulopathy. The calculated low risk then no longer applies to this patient. Such was the case with one patient in our study9. After delivery, the epidural catheter was removed before transferring the patient to the intensive care unit for treatment of the syndrome of hemolysis, elevated liver enzymes, and low platelets, and the subsequent spinal hematoma was diagnosed with delay. The perception of low incidence in the healthy parturient contributes to underestimation of risk when she becomes affected by coagulopathy.

Whereas patient characteristics seem to influence development and outcome after some severe complications, such as spinal hematoma and epidural abscess, no predisposing conditions are found for iatrogenic meningitis. Purulent meningitis will develop in any patient, however healthy, if bacteria are introduced into the spinal fluid, devoid of any immunologic defense. Dr. Baer’s comprehensive review of post–dural puncture meningitis (PDPM) includes reports of three tragic and unnecessary deaths in previously healthy obstetric patients. These cases could reflect a higher incidence of PDPM due to lower hygienic standards in the obstetric setting, lower diagnostic preparedness, or higher motivation to report these cases. Finally, the parturient could be at higher risk of developing PDPM. The reason being that α-hemolytic streptococci are normally part of the flora in the genitourinary tract and fluids containing these bacteria obviously will cover the lower backs of many parturients. As a consequence, faulty skin disinfection before performing a central blockade in the parturient could be more hazardous than in the average surgical patient.

The author and the editorial comment both address the incidence of PDPM.10 Important as this may seem, we would like to quote a recent editorial by Prof. Reynolds: “there can be no such thing as a ‘true incidence’ of an infective complication, . . . as its occurrence will vary with the number of risk factors both in local clinical practice and among the patient population.”11

We agree with Dr. Baer that these three mortalities, the increasing antimicrobial resistance of viridans streptococci, and oropharyngeal presence of more invasive pathogens should be sufficient for every anesthesiologist to adopt truly aseptic technique whenever performing a central blockade.

Analyzing literally every aspect of PDPM, the author does, however, leave one question unanswered: Why do physicians have such an aversion to facemasks? The editorial comment proposes the remedy, advocating shift in culture, guided by responsible leadership and compelling guidelines. To this we can only totally agree. We would also like to add a further question: Shouldn’t all cases of PDPM be subject to epidemiologic evaluation and thorough scrutiny of the hygienic standard in the departments where PDPM has occurred? The polymerase chain reaction is no longer exclusive and expensive, and clarifying the

I have done many spinals and epidurals during 25 yr of practice. Fortunately, none have caused an infection. However, my numbers are not close to approaching 10,000. It is encouraging to learn from Baer’s data3 that the odds that I will have an infection are exceedingly low. I wear gloves and a cap when doing neuraxial anesthesia. Although I have not routinely done so, I will wash my hands before putting on sterile gloves because I will apparently can easily and conveniently introduce bacteria into the spinal fluid.

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pathogenetic pathway in cases of PDPM certainly deserves our attention. After lumbar puncture, the failure of bacterial growth is not uncommon, neither in community-acquired meningitis nor in PDPM. In our series of 29 cases, culture was positive in 12 cases, and 11 of these were α-hemolytic streptococci (not as quoted by Baer). Immediate incubation of cerebrospinal fluid in medium for anaerobic blood culture might favor growth.

Dr. Baer makes the assumption that hundreds of cases with PDPM have gone unreported and unrecognized. This assumption is strengthened by the fact that viridans streptococci are low-grade pathogens that may cause subtle symptoms. In our study, only 14 of 29 patients presented classic symptoms of meningitis. In several of the remaining cases, correct diagnosis of PDPM was reached only because of a high level of suspicion. Worldwide, many cases of PDPM have probably unintentionally been cured by antibiotic treatment intended for some other infection. In view of the numerous reports of PDPM published, it would seem awkward primarily to propose the diagnosis of aseptic meningitis before excluding an infectious origin when presented with a similar case.

One pitfall in the diagnosis of PDPM in the obstetric patient is the anticipation of severe headache after accidental dural puncture. When signs of meningeal irritation such as photophobia or vomiting are present, these might be accompanying symptoms of severe post-dural puncture headache, but the suspicion of PDPM should arise. The combination of headache and infection in a patient recently subject to central blockade should be a warning signal.

As with spinal hematoma and epidural abscess, the symptoms of PDPM often appear after discharge from hospital, and the care of the patient is the responsibility of a physician not necessarily familiar with anesthetic procedures. It is our duty as anesthetists to inform colleagues in other specialties regarding the signs and symptoms of these potentially extremely dangerous complications. An information leaflet distributed among general practitioners regarding post-dural puncture headache has been shown to improve their knowledge of this complication. Similarly, information regarding the rarer, but potentially more serious complications might be of great value.

We should be grateful for the significant contribution offered by Dr. Baer.

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maintain sterility as well as experienced anesthesiologists. These techniques in parturients may be higher risk for infective complications if a laboring patient has skin contamination with amniotic fluid, blood, or other body secretions. Finally, laboring rooms are less likely to provide aseptic conditions when compared with operating rooms.

Even if we assume that the US rate is 1:10,000, why is the provision of general anesthesia to American Society of Anesthesiologists physical status I or II patients nearly 100-fold safer than that of spinal anesthesia? A 1:10,000 risk is neither an ultrasafe system (1:1,000,000) nor a status I or II patients nearly 100-fold safer than that of spinal anesthesia?

...and thoroughly only by routine institution of postoperative visits. I do not necessarily advocate that sterile gowns be used. However, adoption of uniform sterile safety guidelines and continued study of the efficacy of these techniques is important. After all, many of the recently drafted American Society of Regional Anesthesia guidelines on aseptic techniques during neuraxial anesthesia were extrapolated from the medical and surgical literature, and clearly state that a specific outcome cannot be guaranteed.

To clarify the sentence that Dr. Lambert and other readers may have found unclear: "we must institute uniform sterile safety practices that have been proven [hand washing], or seem by common logic to be prudent [facemasks], and continue to study techniques used in other arenas [gowns for central venous catheters] to determine their utility." Evidence has implicated upper mouth commensals in cases of post-dural puncture meningitis. Experience informs us that practitioners talk and sometimes sneeze or cough during a procedure. Because infection control data suggest that the use of facemasks will diminish spread of infectious organisms from droplets, it would also seem prudent to wear a facemask when performing this procedure. I never implied that it is logical that gowns should be used for neuraxial instrumentation. In fact, to quote, "Although Baer states that all aspects of sterile technique are part of the standard-of-care defense, there is no data that support the use of sterile gowns during the performance of neuraxial techniques." I assume that Dr. Lambert wears a mask when doing neuraxial techniques. I am hopeful that he does agree that wearing a mask is a speedy and painless solution to a problem, post-dural puncture meningitis, whose morbidity and mortality dwarf the inconvenience of the mask.

The comments of Drs. Edsall, Moen, Dahlgren, and Irestedt regarding postoperative outcomes measures and root cause analysis deserve a closer look. The American Society of Anesthesiologists' clearly states that anesthesia care is a continuum and that it should be documented as such. The postanesthesia care is more than the stay in the postanesthesia care unit and should include a postanesthesia visit. Although other healthcare providers may inform us of major anesthetic-related complications, we will discover our own complications most quickly and thoroughly only by routine institution of postoperative visits. I completely agree with Drs. Moen, Dahlgren, and Irestedt's recommendation that all patients with evidence of post-dural puncture meningitis be evaluated for the contributing factors including aseptic standard. Educating our medical, surgical, and obstetric colleagues regarding potential complications related to anesthetic practice is a worthy endeavor.

There are two points that, although not related to any of these letters, I would like to raise. The first one has to do with a typographical error in my editorial related to the American Society of Anesthesiologists Task Force on Infection Control. I inadvertently wrote "maximal sterile barrier precautions during central venous catheter infection" rather than "central venous catheter insertion." The second point has to do with the recently published guidelines for aseptic techniques during regional anesthesia. I wrote that although a chlorhexidine solution has a faster and stronger bactericidal effect than povidone iodine, the consensus stopped short of recommending an alcohol-based chlorhexidine antiseptic solution for skin disinfection before neuraxial techniques (electronic personal communication, Joseph M. Neal, M.D., Staff Anesthesiologist, Virginia Mason Medical Center, Seattle, Washington, and Editor-in-Chief, Regional Anesthesia and Pain Medicine, April 2006). However, it seems that in the final revision of the guidelines, the decision was made to encourage the use of an alcohol-based chlorhexidine solution as the antiseptic of choice before regional techniques. The expert panel felt strongly that although the US Food and Drug Administration has not approved chlorhexidine before lumbar puncture, it has a significant advantage over povidone iodine because of its onset, efficacy, and potency (verbal personal communication, James R. Hebl, M.D., Assistant Professor, Department of Anesthesiology, Mayo Clinic, Rochester, Minnesota, November 2006). Upon contacting the Food and Drug Administration, the panel found that the lack of approval was not because of toxicity but because of lack of scientific data. Interestingly, povidone iodine is also not approved for lumbar puncture. Finally, it is important to mention that the guidelines conclude that there are insufficient data regarding the routine use of surgical gowns before performing a regional technique.

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In Reply.—I welcome the letters in response to two articles1,2 and the editorial3 in the August 2006 issue of ANESTHESIOLOGY regarding aspects of infectious complications of neuraxial instrumentation.

van de Beek and de Gans discuss important information related to the treatment of post–dural puncture meningitis (PDPM). They recommend that cefazidime or cefepime be substituted for the empiric third-generation cephalosporin recommendation in my review.1 The former drugs have been found to have greater in vitro activity against Pseudomonas aeruginosa. (However, their reference 4 does not mention either P. aeruginosa or cefepime.) Their admonition against adjunctive steroids in PDPM needs further clarification. Korinek et al. (van de Beek and de Gans’ reference 3) studied 6,243 consecutive craniotomies to evaluate the effect of preoperative antibiotic prophylaxis on the incidence of postoperative meningitis. They found 50% reduction in incision infections (skin, bone) but no reduction in meningitis for the group that received prophylaxis. van de Beek and de Gans give as the reason for withholding adjunctive dexamethasone in PDPM, that PDPM resembles postcraniotomy meningitis more than it resembles community-acquired meningitis. Postcraniotomy meningitis is clearly different from community-acquired meningitis. Adjunctive dexamethasone would be inappropriate in the presence of a wound infection. But PDPM may have more in common with the community-acquired type than it has with the neurosurgical type. Should not PDPM be considered as a distinguished subset? Each of the three types of meningitis has a different spectrum of causative organisms, but the high incidence of viridans streptococci in the PDPM group (a primarily upper respiratory, mouth, and skin commensals) makes it more like the community-acquired (Streptococcus pneumoniae, N. meningitidis) than the neurosurgical type (staphylococci [skin commensals] and enterococci). In addition, the complication of the concomitant surgical wound is absent in PDPM. Therefore, would not the desirable anti-inflammatory effect of dexamethasone be the same in postpuncture meningitis as in community-acquired meningitis (other things being equal, e.g., no other infected foci)?

van de Beek and de Gans’ reference 7, covering meningitis due to viridans streptococci, reports seven cases of meningitis due to viridans streptococci—three of which are termed iatrogenic. Two patients had undergone thermooculation of the gasserian ganglion, and one had endoscopic sclerotherapy for esophageal varices. These three cases suggest meningitis of the post–dural puncture type (albeit inadvertent). It is not clear whether van de Beek’s unpublished cases of meningitis due to viridans streptococci are community-acquired, neurosurgical, or post–dural puncture in type. Two other cases described in van de Beek and de Gans’ reference 7 died of S. milleri meningitis. The underlying cause for these cases of meningitis is not given, but the mechanism of death in each case is given as brain herniation accompanied by cerebral edema. Whether adjunctive dexamethasone is appropriate for treatment in puncture-type meningitis needs further study.

I thank Dr. Edsall for drawing attention to the practice, by some, of injection of air into the epidural space as a possible source of infection. Dr. Lambert’s letter is puzzling. Science is the wedding of logic and observation. Dr. Lambert’s readiness to jettison logic is perverse. He is encouraged that statistics show “. . . that the odds that I will have an infection are exceedingly low.” However, the data reflect incidence expected when the anesthesiologist washes his or her hands. Lambert admits that he has “. . . not routinely done so . . .” but he wants credit for sterile gloves and cap. No mention of a mask. May we conclude that he does not “routinely” wear one? He states, “If the neuroaxial anesthesia infection rates were the same as for [central venous catheter] insertions, no one would argue against the use of neuroaxial full-barrier precautions.” (Isn’t it logical to surmise that if all anesthesiologists were as cavalier about sterile technique, the infection incidence might approach that of inserting a central venous catheter?) He then implies that because the incidence rate of central venous catheter infection is much higher than that for dural puncture, that makes applying the central venous catheter precautions “illogical” because a 1:10,000 infection rate is a “nonproblem.” (It is a serious problem for that unlucky 1 in 10,000.) He asks, “. . . what risk is acceptable?” The answer is that (in the case of prevention of PDPM) the acceptable risk is the lowest possible under conditions of meticulous attention to sterile technique. The idea that there must be a cost–benefit analysis for every intervention, no matter how trivial, is impractical. Why does Dr. Lambert wear a cap and goggles while invading a patient’s nervous system? Where are the data, and where is the logic?

Dr. Moen, Dahlgren, and Irestedt point out an error in the article text, stating that in their series, 28 cases (instead of 11 cases) of PDPM were culture positive for α-hemolytic streptococci. (Table 1 and Table 4 have the correct value.) They ask, “Why do physicians have such an aversion to facemasks?” (Perhaps the situation is analogous to the reaction to automobile seat belts and bike helmets when they were first introduced.) They opine that the unnecessary deaths could reflect, among other things, “. . . lower diagnostic preparedness.” Not only does this serious complication often go unrecognized, but in several of the case reports, the existence of PDPM is denied and attributed to other causes.

The absence of inclusion of PDPM in the US Practice Guidelines7 for the management of bacterial meningitis is inexplicable, as is the Centers for Disease Control and Prevention’s exclusion of PDPM as a nosocomial disease. Perhaps forums such as this one will reduce the incidence, as well as heighten awareness, of this preventable disease.

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To the Editor:—The article by Heller et al.1 was informative and adds precision to the effect of temperature on the baricity of local anesthetics. They provide interesting new data on the temperature at which local anesthetics used for spinal anesthesia are isobaric (the “isobaric temperature”). Clearly, the next question is, what is the clinical relevance of this added precision? The authors themselves state, “Whether this concept in fact improves patient safety in terms of hemodynamic stability or even allows dose reductions of local anesthetics must be confirmed in further clinical studies.”

In 1989, Beardsworth and I published a simple study comparing the injection of 5 ml plain 0.5% bupivacaine at room temperature to an identical solution adjusted to 37°C (very close to but not precisely within the limits [34.3°–35.8°C] of the so-called isobaric temperature).2 The injection was performed with the patients in the lateral decubitus position, and they were then immediately turned to the supine horizontal position. For the same reasons indicated by Heller et al., we hypothesized that increasing the temperature of the bupivacaine would make it more isobaric and limit its spread. We found no difference in the extent of pinprick analgesia. However, the 37°C solution produced a more prolonged block, which we suggested was due to a decrease in pKa associated with the increased temperature.

Beardsworth’s study compared but one dose of bupivacaine and one position after its injection. Other doses and patient positions will likely produce different results.

Heller’s and Beardsworth’s studies beg the question as to whether it is possible (with the exception of using a very hyperbaric solution for saddle or thoracic levels of block) to precisely control the level of spinal anesthesia. Although the temperature effect on the baricity of local anesthetics used for spinal anesthesia reported by Heller has achieved this pinnacle of precision, this effect will have to overcome the manifold factors that control the level of spinal anesthesia3 to significantly impact clinical practice. Whether this can be accomplished will only be determined through clinical trials that will undoubtedly derive from Heller’s publication. However, after 25 yr of studying, practicing, and watching spinal anesthesia, I suspect that the precise control of the level of spinal anesthesia will require more than simply adjusting the temperature of the injected local anesthetic.

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injected at 37°C⁶ are comparatively effective for 2 min and may account for earlier onset of blockade but not, however, for the prolonged LA effects more than 2 h later.

Taken together, the discussed effects carry uncertainty for daily practice but may, besides others, explain the high interindividual ranges in maximum level of sensory blockade reported in many studies using “isobaric” solutions. In vitro studies and modeling as performed in our work¹⁴ always observe and depict a limited part of reality. They never allow conclusions on the reality itself; rather, they may be hypothesis generating or may improve existing hypotheses, which then must be verified (or falsified) in reality. The problems associated with the complex physiology of subarachnoid block may not be solved with simple physics. The intention of our study was to identify isobaric temperatures and, thus, make the course of LA within the subarachnoid space more predictable to improve the nonprecise anesthetic.

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To the Editor—In a recent review of vasopressin, it was stated that there were only two reported cases using bolus vasopressin (10-20 U) to restore blood pressure after pheochromocytoma resection.¹ This letter documents another rare case, using a lower dose of bolus vasopressin, for treatment of catecholamine-resistant hypotension after pheochromocytoma resection.

A 54-yr-old man (height, 180 cm; weight, 84 kg) underwent laparoscopic right adrenalectomy for treatment of pheochromocytoma. Preoperative medications included phenoxybenzamine, metoprolol, ramipril, and atorvastatin. Preinduction blood pressure was 129/74 mmHg, and heart rate was 57 beats/min. During manipulation of the adrenal gland, the patient developed hypertension, which was treated with sodium nitroprusside (up to 10 ml/h of 200 μg/ml) and esmolol (up to 5 ml/h of 10 mg/ml) infusions. After resection and discontinuation of the nitroprusside and esmolol, the patient developed hypotension. A norepinephrine infusion of 24 μg/min was only able to increase the patient’s systolic blood pressure to the low to mid 80s. Two 0.4-U vasopressin boluses were administered, which increased the systolic blood pressure to 120 mmHg. The patient was started on a 4-U/h infusion of vasopressin resulting in maintenance of a systolic blood pressure at 110 mmHg while permitting a decrease in the norepinephrine infusion rate. Both infusions were continued throughout the rest of the surgery and were weaned several hours postoperatively. The patient did well and was discharged home on postoperative day 2.

There are now three previous reports of bolus vasopressin being used to treat hypotension after adrenal resection for pheochromocytoma.²-⁴ Repeated bolus doses of 10-20 U followed by an infusion were required to treat hypotension after pheochromocytoma resection.² In another adult patient, an infusion of vasopressin required 20 min to achieve improvement in blood pressure during pheochromocytoma resection complicated by a large blood loss.² In an 11-yr-old patient, a 5-U bolus followed by an infusion was successful in treating postresection hypotension.⁴

Although vasopressin infusions have been used in a variety of other situations, there are limited data to guide bolus dosing. Others report lower doses of vasopressin bolus. A 2-U bolus dose was used to treat anaphylactic shock.⁵ As in this case, two 0.4-U boluses successfully treated hypotension secondary to both bowel retraction in patients having abdominal aortic resection repair and postreperfusion syndrome during liver transplantation.⁶-⁷ Terlipressin (a vasopressin precursor) in doses of 1 or 2 mg successfully treated hypotension secondary to induction of anesthesia in patients chronically treated with renin-angiotensin system inhibitors.⁸ Additional well-controlled studies must be conducted to establish the indications, safety, and efficacy of bolus vasopressin for rapid correction of hypotension, particularly catecholamine-resistant hypotension.

This patient adds to the small number of reported cases that suggest vasopressin can be safely and effectively used to treat postadrenalectomy catecholamine-resistant hypotension in patients with pheochromocytoma. Although vasopressin is a vasoconstrictor and it is not surprising that it can treat hypotension, there may be a specific need for vasopressin in some pheochromocytoma patients. First, vasopressin is effective in the presence of residual adrenergic blockade and down-regulation of those receptors. Second, in some patients with pheochromocytoma, there is an oversecretion of vasopressin, which may contribute to the induced hypertension.⁹,¹⁰ It is possible that chronic oversecretion of vasopressin leads to a down-regulation of vasopressin receptors, thus contributing to the postresection hypotension. Whether preoperative determination of vasopressin over secretion will affect management is an open question. Catecholamines are also known to inhibit vasopressin release.¹¹ It has been proposed that chronic inhibition by catecholamines may down-regulate neurohypophysial vasopressin synthesis, thereby preventing the acute high release of vasopressin during a hypotensive episode.² Last, the use of...
vasopressin can reduce the catecholamine dose, thus allowing one to avoid their undesirable side effects such as increased myocardial oxygen consumption and ventricular arrhythmias.

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Anesthesiology 2007; 106:884

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To the Editor—With great interest, we read the comprehensive and well-written review article of Drs. Treschan and Peters1 providing a thorough overview of the physiology and therapeutic indications of arginine vasopressin and its synthetic analogs. Nevertheless, we believe that the impact of the long-acting vasopressin analog terlipressin on hepatopla-nchnic perfusion in the treatment of sepsis-related arterial hypoten-sion has not been discussed appropriately. The authors conclude that “terlipressin is a potent intestinal vasoconstrictor, and evidence suggests decreased intestinal perfusion with terlipressin infusion.”1 First, we wish to rectify that the cited study of Westphal et al.2 investigated the effects of arginine vasopressin on gut mucosal microcirculation in septic rats, and not of terlipressin (as wrongly cited by Drs. Treschan and Peters1). Second, the effects of terlipressin on splanchnic perfusion are dependent on two important aspects, which the authors of the current review article did not refer to: (1) the role of aggressive fluid resuscitation and (2) the dose itself. In this context, Asfar et al.3 reported that terlipressin even improved ileal microcirculation in fluid-challenged endotoxic rats. In contrast, in non-fluid-challenged rats, terlipressin infusion contributed to detrimental effects within the intestinal microcirculation and microcirculation. In addition, the impact of terlipressin on intestinal perfusion seems to be dependent on the drug dosage and application form. Again, Asfar et al.4 demonstrated that a goal-directed continuous low-dose infusion of terlipressin not only reversed the hypotensive–hyperdynamic circulation in porcine endotoxemia but also decreased global systemic oxygen consumption without compromising splanchnic metabolism and organ func-tion. In summary, the current literature, also limited in extent, supports the view that low-dose terlipressin in conjunction with aggressive fluid chal-lenge is a promising adjunct in our therapeutic repertoire for the treatment of systemic arterial hypotension resulting from distributive shock.5

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In Reply.—We appreciate the comments of Dr. Roth regarding the use of vasopressin to restore blood pressure after pheochromocytoma resection. This case certainly adds an interesting experience to the few published cases discussed in our recent review.1

The use of a very small vasopressin bolus dose (0.4 U) is a reasonable approach to evaluate the patient’s reaction toward the drug. Dr. Roth used a vasopressin infusion (4 U/h ~ 0.07 U/min) for blood pressure maintenance. This dose is consistent with the recommendations for continuous vasopressin infusion when used as an adjunct vasopressor in septic shock (1–4 U/h ~ 0.01–0.07 U/min).2

Use of vasopressin during pheochromocytoma resection has been described in a few patients with very different preoperative conditions (well-controlled blood pressure vs. hypertensive spells3,4), treated with different anesthetic regimens (intraoperative use of thoracic epidural vs. general anesthesia only5,6), and intraoperative complications (e.g., severe blood loss). Therefore, data are not comparable, and it is much too early to provide treatment recommendations. Undoubtedly, the

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Impact of Terlipressin on Hepatosplanchnic Perfusion: “Only the Dose Makes a Thing Not a Poison” (Paracelus)
role of the vasopressin system is of greatest interest in patients with pheochromocytoma and stresses the importance of the vasopressin system as an important backup system for blood pressure control.³ We agree with Dr. Roth that some patients may have a specific need for treatment with exogenous vasopressin, due to down-regulation and/or preoperative pharmacologic blockade of adreceptors, down-regulation of vasopressor receptors, and/or “inadequately low” vasopressin release during acute hypotension. Further studies are needed to address these issues.

We thank Drs. Lange, van Aken, and Westphal for their comments on the impact of the long-acting vasopressin analog terlipressin on hepatosplanchnic perfusion. Westphal et al.¹⁰ themselves summarized similar results as “data suggest that, in sepsis, vasopressin and terlipressin infusion may decrease gastrointestinal mucosal blood flow.” In our recent review,¹ we concluded that “terlipressin is a potent intestinal vasoconstrictor, and evidence suggests decreased intestinal perfusion with terlipressin infusion.”

We agree with Dr. Lange et al. that this conclusion can be discussed further by taking into account also the role of fluid management and the dose itself. Asfar et al.⁹ used studies in animals to investigate the influence of terlipressin on splanchnic perfusion, and results obtained in pigs show that a continuous low-dose infusion of terlipressin (5–15 μg/kg h) does not have detrimental effects on hepatosplanchnic perfusion, oxygen exchange, and metabolism. However, to our knowledge, this regimen has not been used in clinical trials in humans. Rather, terlipressin is usually administered in intravenous boluses of 1–2 mg. Bolus doses have been used by Asfar et al.¹⁰ in their study on endotoxic rats. The bolus of 6 μg/kg used in this study, however, is only 25–50% of the dose reported to be used in humans, and even lower bolus volumes have not been studied in clinical trials with humans so far. Even with their lower bolus doses, Asfar et al. found a high mortality in endotoxic animals treated with terlipressin alone. Only when terlipressin was administered after adequate fluid resuscitation, ileal microcirculation improved, as expected. Therefore, these latter results support the importance of early and aggressive fluid resuscitation in sepsis¹¹ and also warrant further research on dosing of terlipressin in sepsis. However, until these results are available, terlipressin can not be recommended for routine use in septic patients because of its potentially detrimental intestinal vasoconstrictor activities. That is, what dose it takes to make this drug not a poison is unsettled.

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To the Editor—The difficult airway continues to challenge anesthesiologists. Recently, the development of laryngoscopes that have video cameras built in has led to some improvement in visualization of airway anatomy. One such device is the GlideScope® (Saturn Biomedical Systems, Burnaby, British Columbia, Canada). It is equipped with a patent antifogging system that, together with a design that tends to keep the camera free of blood and secretions, has made visualization of airway structures better. However, despite better glottic visualization, on some occasions the endotracheal tube may still be difficult to pass into the larynx.

We recently provided general anesthesia to an obese female patient, aged 32 yr, weighing 142 kg, with a Mallampati class 4 airway. The patient had a short neck with a hyomental space of three finger-widths. We chose to use the GlideScope® to facilitate the intubation. Although the camera revealed a class II view (only a portion of the vocal cords were visualized), it was impossible to maneuver the endotracheal tube into the laryngel opening even using the stylet supplied by the manufacturer of the GlideScope®. We then removed the stylet while leaving the endotracheal tube tip still visible in the GlideScope® monitor. We threaded a fiberoptic endoscope through the vocal cords into the trachea and then pass the tube over the scope. In essence, the fiberoptic endoscope provides a “controllable stylet” to facilitate entry into the airway.

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Reference

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To the Editor—The GlideScope® Videolaryngoscope® (GVL; Diagnostic Ultrasound Corporation, Bothell, WA, and Saturn Biomedical Systems Inc., Burnaby, British Columbia, Canada) has a video camera incorporated in the undersurface of its curved plastic blade, providing a detailed airway image on an integrated monitor. The shape of the GVL partially resembles the shape of the standard Macintosh laryngoscope (fig. 1A). However, a 60° upward angulation of the distal half of the blade allows for an easy visualization of the larynx, which is often better than that of a rigid laryngoscopy.2 Despite better laryngoscopic view with the GVL, intubation using a Macintosh laryngoscope was significantly faster.2 In addition, in one series of 728 patients, the intubation failure rate of the GVL was 3.7% despite the ability to obtain grade 1 or 2 views most of the time.3–5 The paradox that the GVL provided better glottic visualization but not easy intubation may have been caused by patient-related factors, insufficient skills of intubators, and/or limitations of the device. Intubation with the GVL is limited by a sole reliance on the video image, because a line-of-sight view is nonexistent. We wondered whether this special design of the GVL might actually hinder accomplishment of intubation as a central purpose of the device.

Three steps are necessary for a successful intubation with the GVL: laryngoscope insertion and glottic visualization, delivery of the styletted endotracheal tube (s-ETT) in front of the GVL camera, and guidance of the disengaged endotracheal tube (d-ETT) through the glottis and into the trachea. As described in the operator’s manual, the GVL is inserted down the midline of the tongue and can be used as either a curved blade (Macintosh style) or a straight blade (Miller style). We noticed that some novice intubators actually lever the laryngoscope and halt its advancement as soon as they obtain a glottic view, which can ensue before the tip of the laryngoscope reaches the vallecula. Others insert the GVL too quickly and too deeply and obtain either a close glottic view or an esophageal view. Retracting the GVL from the esophagus provides a close glottic view. The operators’ manual states, “maximum laryngeal exposure may not facilitate intubation.”3 This is contrary to usual attempts made by intubators to obtain the best laryngoscopic view possible. We postulated that such attempts might actually render the passage of the ETT more difficult or impossible, and we explored these observations in an airway model.

We used a Laerdal airway anatomical model 252 500 on which to simulate GlideScope® laryngoscopy and tracheal intubation (figs. 1B and C). The GVL was slowly advanced down the midline of the model’s tongue. The advancement was ceased at three locations: At location 1, the blade tip was at the tip of the epiglottis; at location 2, the blade tip was within the vallecula; and at location 3, the laryngoscope was behind (posterior to) the epiglottis (figs. 2A–C, main panels). The initial position of the laryngoscope at each location was adjusted to give a view of only the arytenoids, grade 2b laryngoscopic view6 (figs. 2A–C, accessory panels in the upper right corner). After performance of tracheal intubation with this initial laryngoscopic view, the GVL position was modified twice at each location. The laryngoscope was lifted first, and the trachea was intubated. The laryngoscope was then levered, with the distal end pointing up, and the trachea was intubated.

Support was provided solely from institutional and/or departmental sources. The authors have no financial relation to the manufacturer of the GlideScope® Videolaryngoscope (Diagnostic Ultrasound Corporation, Bothell, WA, and Saturn Biomedical Systems Inc., Burnaby, British Columbia, Canada) with a visible bulge of the camera that is embedded in the distal half of the GlideScope® Videolaryngoscope blade. The tip of the GlideScope® Videolaryngoscope blade extends above the camera axis. (B) View of the oropharynx and the glottis of a plastic Laerdal airway anatomical model 252 500 (Laerdal Medical LTD, Orpington, Kent, United Kingdom). (C) Side view of the larynx and the trachea of the same model.

Fig. 1. (A) A standard GlideScope® Videolaryngoscope (Diagnostic Ultrasound Corporation, Bothell, WA, and Saturn Biomedical Systems Inc., Burnaby, British Columbia, Canada) has a video camera incorporated in the undersurface of its curved plastic blade, providing a detailed airway image on an integrated monitor. (B) Side view of the oropharynx and the glottis of a plastic Laerdal airway anatomical model 252 500 (Laerdal Medical LTD, Orpington, Kent, United Kingdom). (C) Side view of the larynx and the trachea of the same model.

The same course of action was followed at locations 1, 2 (figs. 3A and B), and 3. We performed the whole process of nine intubations twice: the first time using a recommended 60° stylet angle and the second time using a 90° stylet angle. A lubricated 5.5-mm s-ETT was used to minimize adhesion between the ETT and the model structures. The ETT was loaded on a malleable stylet with the ETT bevel facing to the left for all intubations. The intubator’s hands maneuvering the laryngoscope and the s-ETT were recorded using a camcorder, while the passage of the d-ETT through the glottis was captured from the GVL video output (figs. 2 and 3, main panels and accessory panels, respectively). These two videos were synchronized and processed using video editing software (Adobe Premiere Pro 1.5; Adobe Systems Inc., San Jose, CA). Two compiled videos were then reviewed simultaneously.

Because of softness of the tongue, lifting the laryngoscope at location 1 misdirected the camera axis from the arytenoids toward the vallecula, shifting the view from grade 2b to grade 3. Gentle lifting of the GVL at locations 2 and 3 enhanced the laryngoscopic view from grade 2b to grade 2a. Levering the GVL pointed the camera axis upward as to provide visualization of the anterior portion of the glottis (fig. 3B). During this phase, the intubator purposefully avoided lifting the laryngoscope to avoid lifting the glottic structures. Extremelevering of the laryngoscope provided a grade 1 view at locations 1 and 2. The position of the camera close up to the glottis prevented visualization of the most anterior glottic portion at location 3. Insertion of the s-ETT and advancement of the d-ETT was easier and quicker at location 2 than at locations 1 and 3. Advancement of the d-ETT was easier and...
The time to intubation was shorter using the 60° stylet angle than the 90° stylet angle.

The GVL gently lifted within the vallecula provided a grade 2a laryngoscopic view and yielded the smoothest and quickest intubation using the 60° stylet angle. Adequate room for delivery of the s-ETT, optimal alignment of the camera axis with the laryngotracheal axis, and decreased impact of the d-ETT tip with the anterior tracheal wall are the most probable explanations (fig. 3A). The Miller-style placement of the GVL resulted in a close glottic view but reduced the space between the GVL camera and the glottis for the s-ETT insertion. We recommend the Miller-style use of the GVL only if the best laryngoscopic view with the Macintosh style is a grade 3 view. Levering the GVL shifts the proximal end of the laryngoscope down and brings more bulk of the GVL blade into the oropharynx. That will severely reduce the space available to pass the ETT, especially if intubators attempt to pass the s-ETT underneath the scope. Levering the GVL also produces upward orientation of the camera portion of the blade such that the d-ETT that is passed alongside the blade easily gets hung up on the anterior commissure or cricoid or tracheal cartilages (fig. 3B). In either case, although the view is improved, accessing the laryngeal inlet and advancing the tube may be more complicated, resulting in failed intubations.

In conclusion, several considerations support our suggestion that maneuvers necessary to achieve a grade 1 laryngoscopic view may render intubation with the GVL more difficult. We believe that a grade 2a view with the blade lifted within the vallecula is preferable for intubation with this device. It provides the adequate space in the oropharynx and in the immediate glottic area for the s-ETT insertion as well as optimal alignment of the camera axis with the laryngotracheal axis for ETT advancement.

The use of an open airway model does not, of course, completely model the challenges of tracheal intubation in patients. However, the use of the open model allowed us to visibly demonstrate both good and bad laryngoscopic maneuvers and their corresponding glottic views. We hope that this letter may bring forth more understanding to GVL users about proper laryngoscopic and intubating maneuvers and may guide them to more intubation success with the device.

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