pean countries. The number of blood products given to patients in 1,000 inhabitants is 40 in France, 89 in Denmark, and 73 in Germany. Nevertheless, we should like to pinpoint the findings of the study by Lienhart et al. published in this same journal. This survey used the French death certificates national database to assess mortality related to anesthesia in France in 1999. The major finding of this survey was the reduction by a magnitude of 10 of the anesthesia-related mortality rate in France, as compared with a previous survey 20 yr ago. The analysis of the causes leading to the perioperative deaths was very enlightening. It was estimated from this survey that nearly 100 deaths occur perioperatively in France each year as a result of inadequate blood management. Surprisingly, more deaths partially related to delayed or absent blood transfusion were observed, and only a small proportion of complications occurred after an episode of transfusion. In many cases point-of-care monitoring of hemoglobin was not used to estimate blood loss, although it is likely that these inexpensive devices were already available in most hospitals at that time. Blood loss associated with delayed or absent blood transfusion caused not only intraoperative hypotension and hypovolemic shock, but also postoperative myocardial ischemia and infarction in patients with preexisting coronary artery disease. It seems impossible to know if the use of restrictive threshold for blood transfusion is responsible for this situation. After this nationwide study, the French Society of Anesthesia sent to its members key messages focusing on blood transfusion during the perioperative period: Quick diagnosis, threshold respect, and guideline implementation.

On one hand, a body of evidence is growing on short-term and long-term complications of homologous transfusion, but on the other hand, facts suggest that patients may die of mistreated perioperative anemia.

In Reply.—We thank Dr. de Saint Maurice et al. for their comments regarding our editorial view and share their concerns over perioperative deaths as a result of inadequate blood management. We could not agree more with their view that not measuring the hemoglobin concentration consecutively during major hemorrhage is substandard care, as is not treating severe hypovolemia or hypotension in such situations.

This is what patient blood management is all about; patient blood management is not “just say no to blood transfusions.” Patient blood management is based on three pillars: Detecting and treating preoperative anemia, reducing the loss of red blood cells perioperatively, and optimizing the treatment of anemia. Red blood cell transfusions may be administered if all other options have been used and the patient starts showing signs of inadequate oxygenation. Of course, the quick correction of hypovolemia, hypotension, tachycardia, and arrhythmia is an integral part of patient blood management.

It is of utmost importance not to confound the momentary helpful effect of red blood cell transfusion on hypotension and hypovolemia with an outcome benefit. Red blood cell transfusions are indisputably associated with an increase in mortality, major adverse cardiac and noncardiac outcome, acute lung injury, nosocomial infection, tumor growth, duration of hospitalization, and cost.

Therefore, there is an urgent need for change, and the Governments of Western Australia and the Canton of Zurich, Switzerland, are to be congratulated again for taking the lead in sustainably implementing patient blood management and thereby improving patient outcome.

Donat R. Spahn, M.D., F.R.C.A., Holger Moch, M.D., Axel Hofmann, M.E., James P. Isbister, M.B., F.R.A.C.P., Hospital Zürich, Zürich, Switzerland. donat.spahn@usz.ch

References


Anesthesiology 2009; 111:445–6

We wanted to emphasize this point after reading these articles, but of course “our own blood is still the best thing to have in our veins.”

Guillaume de Saint Maurice, M.D.,* Françoise Pequignot, M.D., Yves Auroy, M.D., Ph.D., Albertine Aouba, M.D., Dan Benhamou, M.D., Eric Jougla, Ph.D., André Lienhart, M.D. Percy Military Teaching Hospital, Clamart, France. gsmopex@yahoo.fr

References


(Accepted for publication April 8, 2009.)
To the Editor—Nouruzi-Sedeh et al. demonstrated that diverse medical personnel who received only manikin training for tracheal intubation using the GlideScope® (GVL, Verathon Medical Europe, Ijsselstein, Netherlands) and Macintosh laryngoscope had significantly higher intubation success on a limited number of patients using the former technique (93% vs. 51%, respectively).

At first glance, this result may appear surprising, but a closer look provides an explanation and may provide some direction for future research on the subject.

In a study that examined learning of direct laryngoscopy (DL), Mulcaster et al. demonstrated that “proper insertion and lifting of the laryngoscope” are crucial to performance of tracheal intubation using DL. They also concluded that teaching DL and tracheal intubation using manikins only is inadequate. In the current study, Nouruzi-Sedeh et al. point out that the main difficulty encountered by their inexperienced operators was attaining a Cormack and Lehane (C&L) Grade I or II view of the glottis. Once attained, tracheal intubation was successful. When the operators only attained a C&L Grade III or IV view, intubation failed.

Two studies comparing the Macintosh laryngoscope and the GVL have demonstrated improvement by one C&L grade laryngoscopic view in most patients using the GVL. This difference seems to be exaggerated by manikin-only trained operators, and it was crucial for their success or failure of intubation in the current study. In table 1, the authors report that operators have obtained C&L Grade I or II views in 92% of patients using the GVL, and only 50% of patients using DL. Because the figures of intubation successes and failures mirror the laryngoscopy figures, inability to display the glottis using DL resulted in a significant number of intubation failures in that group. However, when the attending anesthesiologists took over the intubations, they were able to obtain Grade I and II C&L views in all but one patient in each group, and were able to intubate all those patients. It seems that as soon as study candidates performed three laryngoscopies and successful intubations of a single manikin airway using each device, they qualified for study participation without exposure to simulated difficult airway situations that would eventually provide more experience before their exposure to real airways. Depending on the specific criteria for these variables, there may have been different final study results.

The real question raised by the results of this study is: “What methods should we use, and when should we introduce them to teach tracheal intubation to anesthesia trainees and nonanesthesiologists?” Intubation using DL has been a standard of care procedure for more than 60 yr. The availability of equipment is ubiquitous, it is less expensive, and its maintenance is easier and simpler than the GVL. Since introduction of the GVL in airway management, it has been demonstrated that DL provides the same success rate of otorrhachal intubation within a shorter timeframe than the GVL when used by experienced operators. However, two previous studies examining the pattern of learning DL, along with this study, have demonstrated that learning tracheal intubation using DL requires a longer training period than intubation using the GVL to achieve an intubation success rate of 90% or more.

Based on their results, Nouruzi-Sedeh et al. conclude that use of the GVL may provide significant improvement in the rate of successful intubation for those who are learning how to intubate or those who only occasionally perform tracheal intubation. The authors may be raising a real dilemma here. I would agree that introduction of a videolaryngoscope early in training may provide an early additional airway management experience that temporarily provides better intubation success, and may enable attending physicians to guide tracheal intubation while observing the monitor. However, it may be concerning that there are nearly a dozen published reports regarding oropharyngeal soft tissue injury while intubating with the GVL. To me, as a long-time DL user and an experienced GVL user, the latter device has been excellent as either the initial, backup, or rescue tool for anticipated difficult or failed intubation using DL. Early use of a videolaryngoscope in training of anesthesia personnel, however, may potentially cause slower and/or poorer development of DL skills because of limited exposure to difficult laryngoscopies using DL. Similar concerns have been voiced in Great Britain because of widespread use of the laryngeal mask airway. The other dilemma is whether we should teach the use of the GVL and laryngeal mask airway instead of DL to medical personnel who cannot get extensive airway management training on patients to master DL, and who perform tracheal intubations only on occasion. I believe that both these questions remain open until further research provides more scientific evidence.

In conclusion, use of DL for tracheal intubation is effective and efficient by experienced users, but requires a longer training period than the GVL for intubation success of more than 90%. Conducting further research into the issues raised by Nouruzi-Sedeh et al.’s study may inspire us to develop new and appropriate airway teaching models for anesthesia trainees and nonanesthesiologists.

Mirsad Dupanovic, M.D., Kansas University Medical Center, Kansas City, Kansas. mdupanovic@kumc.edu

References