regarding the safety and efficacy of MILS\textsuperscript{7} and wide variability in MILS technique, we would welcome the development of a consensus statement regarding how MILS is to be applied and the clinical endpoints to be achieved. We need to understand what MILS truly is before we can determine what it truly does; to determine if MILS is safe and effective or, possibly, otherwise.

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To the Editor—We read with interest the study by Bilotta \textit{et al.}\textsuperscript{1} comparing intensive insulin therapy to conventional treatment in two cohorts of neurosurgical patients. When an arterial catheter was not available for glucose determination, capillary blood was measured with the HemoCue point-of-care device (HemoCue, Angelholm, Sweden). This was a wise choice, as this system has been shown to be accurate, even at low glucose concentrations.\textsuperscript{5} What is not commonly appreciated is that most other point-of-care glucose measurement devices are not sufficiently accurate for critical care use, and that such devices originally approved and regulated for home self-monitoring by patients with diabetes have migrated into the hospital setting without further regulatory scrutiny. In fact, it has been specifically recommended that point-of-care devices designed for patient use at home, yet sometimes used in hospitals, should not be used in critically ill patients.\textsuperscript{3}

Although their use of capillary blood for glucose determination is understandable, it should be pointed out that arterial blood glucose concentrations have been demonstrated to be a better representation of plasma glucose as compared with simultaneous capillary measurements.\textsuperscript{4,5} This may be secondary to a variable time constant in the fingertip blood pool. Furthermore, hypotension, hypoxia, and acidosis, which are common problems in the critical care population, can significantly affect these capillary readings.\textsuperscript{6}

Not all glucose measurements are equivalent, and care must be taken in their interpretation, especially at low concentrations.

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\textit{In Reply—}Dr. Rice \textit{et al.} have raised a very interesting question about our article published in the March 2009 issue of \textit{Anesthesiology},\textsuperscript{1} that concerns the accuracy of the glycemic measurements on capillary blood samples. We agree that the most reliable measurement of blood glucose concentration is on blood samples obtained by arterial line. Generally, the measurement of blood glucose concentration through the HemoCue B-Glucose analyzer (HemoCue, Angelholm, Sweden) with peripheral capillary blood is considered to be reliable in noncritical patients.\textsuperscript{2,3} Thus, previous studies even in critical care patients have used this approach, including the one by Van den Berghe \textit{et al.} that specified: “The dose of insulin was adjusted according to whole-blood glucose levels, measured at 1- to 4-h intervals in arterial blood or, when an arterial catheter was not available, in capillary blood, with the use of a point-of-care glucometer (HemoCue B-glucose analyzer, HemoCue).”\textsuperscript{4} Our protocol is similar to that of Van den Berghe \textit{et al.}, but we hypothesized that in our patients population, which is relatively younger than in previous studies, the risk of hypotension, hypoxia, and acidosis is lower.

Nevertheless, as we have mentioned in our article, to overcome the risks of this bias we have performed the measurements of blood glucose concentration exclusively on capillary blood samples only in few cases (\textit{i.e.}, patient in which was difficult to get arterial blood sample: <5\% of the measurements). Thus, “in all patients, glucose concentrations were measured in whole blood or on undiluted arterial blood rather than capillary blood samples.” Furthermore, as we reported in the paper, we have made systematic cross controls.

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\textit{All Glucose Measurements Are Not Equal}

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