CORRESPONDENCE

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In Reply: — We regret any injury, however minor, that occurs with a Becton Dickinson product, especially one designed for greater safety. The evidence demonstrates that InterLink, by substituting a blunt plastic cannula for a sharp steel needle, reduces the risk of spreading bloodborne pathogens by needlestick injury. In our 5 yr of selling InterLink in the United States, we have no similar report of a cut from the blunt cannula before Dr. Miyaskas’s Japanese hospitals usually use iodophors rather than alcohol to disinfect injection sites. Iodophors dry slowly and may make the site more slippery. Health professionals in the United States and Australia who use InterLink extensively swab the site most commonly with alcohol. We have an active project improving the InterLink cannula and we will investigate the implications of iodophor usage more extensively as a consequence of this report.

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Linear Reverberation in the Ascending Aorta: A Cause of Multiplane Transesophageal Echocardiographic Artifact

To the Editor: — Reverberations are important potential echocardiographic artifacts commonly encountered during imaging of the thoracic aorta because of the presence of smooth, highly reflective tissue-fluid and tissue-air interfaces. Linear artifacts in the ascending aorta, which mimic intimal flaps, were seen in 44% of patients with a monoplane transesophageal echocardiography (TEE) and in 50% of patients with a bplane TEE in series published by Appelbe and coworkers.1 These artifacts were associated mainly with dilation of the ascending aorta. It was proposed that multiplane TEE might be useful to provide additional views and improved diagnostic accuracy of aortic dissection.2 We present a case of reverberation artifact mimicking an aortic root dissection with a multiplane TEE probe. A 55-yr-old man was admitted after a road accident. Initial evaluation demonstrated intracranial trauma and multiple extremity and rib fractures. In the emergency unit, hemodynamic stabilization required volume loading and initiation of inotropic support. The patient was transferred to the operating room for treatment of his extremity fractures. Because of hemodynamic instability, it was decided to initiate intraoperative TEE monitoring. Systematic examination performed with a multiplane 5-MHz probe revealed the presence of a linear structure in the proximal ascending aorta in the transverse and longitudinal planes (fig. 1) resembling an intimal flap and suggesting an aortic root dissection. Diagnosis was critical in the context of chest trauma but obvious after careful echocardiographic examination by obtaining images from different incidences. The linear structure had indistinct borders, did not display rapid oscillatory motion, was parallel to the posterior aortic wall (PAW), and was located at twice the distance from the right pulmonary artery posterior wall (RPAPW) as from the PAW. This artifact could be generated when the echo of the PAW is bounced back from the transducer or could correspond to a reverberation from a moving target, the RPAPW, and a moving mirror, the PAW, as recently described by Evangelista and coworkers.3 In addition, color Doppler did not show interruption of the flow pattern and assisted the differential diagnosis between an artifact and an intimal flap. This case illustrates the possibility of artifact in the ascending aorta with multiplane TEE and the necessity of defined echocardiographic training to avoid erroneous diagnosis and recognize pitfalls with TEE.

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Fig. 1. Two-dimensional transesophageal echocardiographic basal transverse and longitudinal views of the great vessels showing linear reverberation in the ascending aorta (arrow). AA = ascending aorta; RPA = right pulmonary artery.

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Preemptive Analgesia Implies Prevention

To the Editor.—The editorial by Kissin' rightly calls attention to the many difficulties facing the investigator who seeks to demonstrate the clinical phenomenon of preemptive anesthesia. To his balanced words, I add that I believe semantic confusion has arisen because of misuse of the word “preemptive.” Increasingly, this word is equated by those who conduct clinical trials or review the literature with “preoperative” or “pre-incision.” In the animal literature, however, the term “preemptive” refers to measures that prevent sensitization of cells within the spinal cord dorsal horn and other key sites within pain pathways. By definition, preemptive interventions in animal models must be accomplished before the onset of nociception. Conversely, preoperative or pre-incisional measures that could not possibly be viewed as preventing dorsal horn sensitization have been tested as if they were preemptive in the preceding sense. For example, the administration of single dose of a nonsteroidal antiinflammatory drug, or a single low dose of an opioid preoperatively, have been evaluated in clinical trials whose results are then discussed as tests of “preemptive analgesia.”

It is clear from the preclinical literature that preemptive means “preventive,” not simply “before.” Preemptive analgesia, like many other potentially worthwhile advances in medicine, would be abandoned if its initial, sometimes uncontrolled implementation were viewed as a final test of its value. Cardiopulmonary bypass, blood transfusion, organ transplantation, and the use of muscle relaxants are but a few examples. Kissin does well to caution his colleagues that even effects that do exist and that may be of extreme importance are not always evident. For these reasons, we should not allow linguistic impression to compound our difficulties when evaluating this important concept.

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