**CORRESPONDENCE**

Anesthesiology  
1996; 84:259  
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Lippincott-Raven Publishers

**In Reply.**—I appreciate the interest of Butler and Kenny in our method of preoxygenation. We did not intend to imply that this method alone would achieve an optimal alveolar oxygen fraction. However, in patients who refuse placement of a mask on their face, the method we describe is superior to no preoxygenation.

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**Reference**


(Accepted for publication September 29, 1995.)

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**Placement of an Endotracheal Device Via the Laryngeal Mask Airway in a Patient with Tracheal Stenosis**

To the Editor.—Treatment of tracheal stenosis by means of the insertion of endotracheal prosthesis1 through the endotracheal tube (ETT) is difficult. A patient with tracheal stenosis in whom laryngeal mask airway (LMA) was successfully used to place a metal-stent prosthesis is reported.

A 39-year-old woman, height 156 cm, weight 56 kg, with idiopathic subglottic tracheal stenosis and vocal cords synchiae underwent several surgical interventions with immediate but short-term clinical improvement. An expandable metal tracheal stent was inserted via an ETT (size 7.5, Mallinckrodt) and fluoroscopic monitoring under general anesthesia, but a computed tomographic scan revealed distal displacement 48 h after the insertion, producing increased respiratory symptoms. A second endoprostheses was inserted, this time via an LMA (fig. 1). After preoxygenation, anesthesia was induced with propofol (2.5 mg/kg) and fentanyl (20 mg), and a size 4 LMA was inserted. Anesthesia was maintained with a mixture of 50% air/oxygen and an infusion of propofol (0.16–0.11 mg·kg⁻¹·min⁻¹). The extent of the stenosis was evaluated using direct visualization through a flexible fiberoptic scope (Olympus LF-1, Tokyo, Japan) aided by fluoroscopic monitoring; radioopaque marks were drawn on the neck at the level of the superior and inferior borders of the stenosis. The leader catheter of the stent was introduced through the LMA and was directed to the stenosed area by direct visualization aligned with the radioopaque skin markers. Once in position, the stent was advanced to the stenotic area, and the leader was withdrawn. To facilitate the handling of the instruments, the aperture bars of the LMA were removed before its positioning.

Fig. 1. Prosthesis and fiberoptic scope through laryngeal mask airway.

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Electrocardiogram Ordering Practices among Anesthesiologists

To the Editor.—Several authors have questioned the value of the routine preoperative electrocardiogram (ECG) for healthy patients. We surveyed all U.S. and Canadian teaching hospitals and attempted to survey an equal number of hospitals of the same size without teaching programs to learn current practices for preoperative ECGs. A total of 182 teaching hospitals and 270 nonteaching hospitals received surveys. The percentage of hospitals responding to the survey was 94% for teaching and 49% for nonteaching institutions.

Our survey found that more than 60% of both teaching and private institutions ordered preoperative ECGs for men older than 40 yr, and more than 80% ordered preoperative ECGs for women older than 50 yr (table 1). By comparison, a consensus development panel convened by the University Hospital Consortium concluded that preoperative ECGs should be ordered in all men older than 40 and all women older than 50 and all others with specific clinical indications (19 respondents, 66% agreement). Although the practice of ordering preoperative ECGs for men older than 40 and women older than 60 yr is common, almost one-third of the hospitals we surveyed recently increased the age at which an ECG is ordered. In 25% of the hospitals surveyed, preoperative ECGs are required by hospital policy rather than anesthesia department policy, and about 25% of the hospitals surveyed reported that surgeons ordered ECGs independently of anesthesia department guidelines. Approximately 10% of the hospitals surveyed stated that third-party payers now dictate the patient age for which preoperative ECGs will be paid. Finally, 72% of respondents believed that health status was more important in ordering an ECG than either age or type of procedure.

We believe our survey indicates that preoperative ECG ordering practices are changing and that the majority of anesthesiologists are prepared to order ECGs based on the patient’s health status rather than age. We speculate that, as managed health care increases, clinical justification will be required before ordering a preoperative ECG. The results of our survey may be helpful to others in formulating policy in an era of managed health care.

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Table 1. Minimum Age at Which Anesthesia Departments Routinely Order Electrocardiograms for Patients without Cardiac Risk Factors

<table>
<thead>
<tr>
<th>Minimum age at which department routinely orders electrocardiograms on men older than (yr)</th>
<th>Teaching</th>
<th>Non-Teaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>2.3 (0.9, 3.6)</td>
<td>1.8 (0.2, 3.4)</td>
</tr>
<tr>
<td>40</td>
<td>66.2 (62.0, 70.3)</td>
<td>63.6 (58.0, 69.3)</td>
</tr>
<tr>
<td>50</td>
<td>24.8 (21.0, 28.6)</td>
<td>25.9 (20.3, 30.6)</td>
</tr>
<tr>
<td>60</td>
<td>6.0 (3.9, 8.1)</td>
<td>9.1 (5.7, 12.5)</td>
</tr>
<tr>
<td>70</td>
<td>0.8 (0.1, 1.8)</td>
<td>0 (0, 2.3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minimum age at which department routinely orders electrocardiograms on women older than (yr)</th>
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</thead>
<tbody>
<tr>
<td>30</td>
<td>2.3 (0.9, 3.6)</td>
<td>0.9 (0, 2.3)</td>
</tr>
<tr>
<td>40</td>
<td>45.5 (41.0, 49.9)</td>
<td>46.8 (40.9, 52.7)</td>
</tr>
<tr>
<td>50</td>
<td>38.6 (34.3, 43.0)</td>
<td>41.3 (35.4, 47.1)</td>
</tr>
<tr>
<td>60</td>
<td>12.9 (9.9, 15.9)</td>
<td>11.0 (7.3, 14.7)</td>
</tr>
<tr>
<td>70</td>
<td>0.8 (0.1, 1.8)</td>
<td>0 (0, 2.3)</td>
</tr>
</tbody>
</table>

Data are presented as percentages with 95% confidence intervals in parentheses.