optimal depth of its insertion into the DLT. The modified design needs only be produced in the small and medium sizes.

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Transesophageal Echocardiography in Pediatric Cardiac Surgery

To the Editor—The recent fine paper by Muhiedeen et al.1 and the accompanying editorial by Weintraub and Sahn2 admirably outline the complexities as well as the strengths and weaknesses of intraoperative transesophageal versus epicardial echocardiography used during surgical repair of congenital heart disease. They rightly point out that transesophageal echocardiography provides accurate assessment of surgical repairs of complex congenital heart defects, with the caveat that assessment of right ventricular outflow tract anatomy and valvular regurgitation is unreliable with currently available pediatric transesophageal echocardiography.

The degree of expertise and technical complexity evident in this report, the multidisciplinary authorship of the paper, and its appearance in an anesthesiology journal all beg the question: is it reasonable to expect that anesthesiologists can realistically do intraoperative transesophageal echocardiography assessments of complex congenital heart disease repairs? Furthermore, who watches the patient during the sometimes prolonged intraoperative transesophageal echocardiography assessment during the period of instability after bypass following a flawed surgical repair?

Intraoperative transesophageal echocardiography assessments that prompt surgical revision of complex congenital repairs during cardiopulmonary bypass should be at least as expert as the original preoperative decision for surgical repair itself. Anything less is unacceptable because the risk of reintroduction of bypass and revision of a complex repair may be substantial, particularly when the original bypass and aortic cross-clamp times have been prolonged. In our own institution, the pediatric cardiac anesthesia staff, who are also board certified in pediatric radiology, do not feel qualified to make such judgments with the degree of expertise necessary to justify such risks; when such decisions are made, full-time echocardiographers are involved. Given that the American Heart Association recognizes 55 forms of congenital heart defects and that there are a number of variants of each form,3 one must ask: is it reasonable for an anesthesiologist who does not have extensive formal training for and ongoing concentration in echocardiographic diagnosis of congenital heart defects to make such decisions?

While these questions may well be beyond the scope of the study,1 such questions are important and arise because of the publication of such a paper. These questions were not addressed either by the authors1 or by the writers of the accompanying editorial.2 Although similar questions arise in the use of transesophageal echocardiography for assessment of valvular repairs and ventricular function during and after coronary artery bypass graft procedures, in the case of repair of congenital heart disease these issues are considerably more prominent and deserve comment.

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