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(Accepted for publication January 21, 1990.)

Anesthesiology 72:773, 1990

In Reply—I would like to thank Drs. Roizen and White for their thoughtful and provocative comments on the conduct of the anesthetic and our conclusions surrounding the events detailed in the Case Report. The point that I wished to make in presenting this patient is the potential fallibility of conscientious physicians and "check-off form(s) or . . . automated system(s)" in screening for unusual disease processes in unlikely patients.

Postoperative evaluation permits the use of much higher magnification in the scrutiny of adverse events, as Drs. White and Roizen have nicely demonstrated in their letter, and yet a cause could not be established for this patient's cardiac event immediately after the case. He specifically denied a drinking problem, although his family later confirmed a significant alcohol intake. In a quiet recovery room, on listening specifically for adventitious heart sounds, only a soft fourth heart sound could be heard. An EKG showed persistent sinus tachycardia, right atrial enlargement, left axis deviation, a nonspecific intraventricular conduction delay, and inverted anterolateral T waves. Assuming this was his baseline EKG and that it was available preoperatively, "a more exhaustive evaluation of (this) apparently healthy, active young man" would have occurred at this institution. This does not negate Dr. Roizen's contention1 that routine preoperative EKGs are unwarranted in patients under 40. Unfortunately, some patients at increased risk for anesthesia will pass through reasonable screening procedures.

In summary, we anesthetized a seemingly vigorous patient with titrated, albeit generous doses of anesthetic which resulted in a cardiac arrest (by any other name). We subsequently discovered an occult disease process which accounted for his near demise. Specifically addressing some of the points made by Drs. Roizen and White, we do not ask questions relating to alcohol consumption in our health survey, and perhaps should; but the knowledge that the patient consumed large amounts of alcohol along with his athletic history would justify the use of more induction agent rather than less. As an internist, and a veteran of the Veteran's Hospital system, I would also stress that it is not standard procedure to practice to all patients with a history of alcohol usage for alcoholic cardiomyopathy.

I would like to thank Dr. Herschman for describing the concerns surrounding anabolic steroid use in athletes. This patient's anesthetic was administered in 1987 at a time when the prevalence of steroid use was unrecognized, and I suspect its risks are still underestimated. We did not question this patient about steroids, although I should note that this patient had a dilated cardiomyopathy rather than the concentric hypertrophy noted by Dr. Herschman.

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(Accepted for publication January 21, 1990.)

Anesthesiology 72:773–774, 1990

Transtracheal Jet Ventilation. I.

To the Editor—Benumof and Scheller provide a comprehensive review of the theory and technique of transtracheal jet ventilation.1 I agree that this equipment should be immediately available to every anesthesiology practitioner. It should also be available on at least one hospital-wide crash cart connected to an oxygen cylinder with a DISS fitting, as shown in their table 3, as emergencies occur in hallways and other areas remote from a piped-in oxygen source.

However, the authors state that as a last alternative, an iv catheter can be connected to a self-inflating bag-valve unit via a 15-mm adaptor for a 3-mm 1D endotracheal tube. Yealy et al.2 have shown that while