Correspondence

TRACHLIGHT™ - Learning tips

To the Editor:

After I had performed more than 100 Trachlight intubations, (five difficult - grade 3 view by direct laryngoscopy), I found that the following tips improve successful intubations with a light wand during the learning period:

1. Dimmed OR lights and one size smaller ETT (6 mm for female, 7 mm for male patients will be very helpful for a successful beginning.
2. Insert Light wand in the mouth with the right hand - start "on side" (right side of the mouth) and then rotate the wand medially towards the tip of the chin.
3. Use the left hand to elevate the jaw as much as possible.
4. Keep "rocking" the wand back and forth until the light glow is in the midline of the neck.
5. The stylet must be bent at the right length according to individual patient airway features (it is important to assess the patient's anatomy and to estimate the distance between the back of the pharynx and the cords - the "arm", the stylet's bent tip, should be bent at that length) - too short arm: ETT can not be advanced, in spite of the bright midline light - too long arm: difficult to find the midline, esophageal intubation very likely.
6. Correct angle - arm has to be bent at least 90°.
7. "Loss of resistance" and/or "click" can be felt when ETT is advanced under the epiglottis and through the cords.
8. Daily practice on "normal" airway is a prudent strategy during the learning period.

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Loss of resistance to saline - does the dripping bother you?

To the Editor:

The loss of resistance (LOR) technique is commonly used with either air or saline to identify the epidural space. LOR to air is simple and has been used for many years. Reported problems¹ include subarachnoid or intravascular injection of air resulting in headache or venous air embolism, and introduction of air bubbles into the epidural space possibly impairing spread of local anesthetics. Thus, some practitioners recommend LOR to saline as the preferred technique because it has not been associated with any of these complications.¹ However, one of the major disadvantages of this technique¹ is that it introduces fluid into the epidural space, which can be confused with a "wet tap". Tests have been described to determine the origin of the dripping liquid including warm temperature or glucose content as indicative of CSF. Recently, we reported a new test to determine epidural catheter placement using nerve stimulation^{2,3} which seems to have the ability to distinguish subarachnoid (bilateral motor response at low current less than 1mA) from epidural (motor response at higher current between 1 to 10mA) placement. In our practice, the new test allows for LOR to saline to be practiced more readily as a few drops aspirated out from the catheter need not be confusing. This test may allow greater peace of mind as it seems to identify the true position of the catheter and to rule out subarachnoid placement when a few drops of liquid drip back from the catheter after using LOR to saline.

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Transthoracic echocardiography in perioperative medicine

To the Editor:

With the growing trend towards minimal preoperative testing, we commonly encounter ambulatory surgery patients with incomplete preoperative assessments.¹ Medical consultations on the day of surgery (with or without additional testing), almost inevitably result in postponement or disruption of the planned surgical procedure.

Recent practice guidelines suggest that a transthoracic echocardiography (TTE) examination is often sufficient to exclude major cardiac pathology in patients scheduled to undergo surgical procedures with low cardiac risk.¹ Echocardiography allows one

to confirm or rule out common cardiac causes of dyspnea, such as left ventricular hypertrophy, valvular disease, diastolic dysfunction, cardiomyopathy, all of which represent major clinical predictors of cardiac risk.^{1,2}

After formal training in the echocardiography laboratory,³ several anesthesiologists in this department have become adept in the performance of a basic TTE examination. They recently used echocardiographic equipment from the operating room to exclude severe aortic stenosis in one patient, left ventricular dysfunction in another, and to diagnose hypovolemia in a third (Figure).⁴ The information obtained by TTE greatly facilitated patient care. It prevented unnecessary delays of surgery and additional testing in the first two patients. Hospitalization, invasive monitoring and an extensive cardiac work-up were avoided in the third patient.

While, traditionally, anesthesiologists have not considered TTE within the scope of their practice or knowledge, new economic realities and the wish to be perceived as perioperative physicians, may force a reassessment.⁵ For anesthesiologists to become effective as perioperative physicians, anesthesia training may need to be adjusted to also include formal instruction in TTE.

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FIGURE Parasternal long axis two-dimensional echocardiogram demonstrates marked hypertrophy of the left ventricle with small left ventricular cavity.

Legend: LA- Left atrium, LV- Left ventricle, RV- Right ventricle

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