5 Myles PS, Hunt JO, Nightingale CE, et al. Development and psychometric testing of a quality of recovery score after general anesthesia and surgery in adults. *Anesth Analg* 1999; 88: 83–90.

Anesthesia in the prone lithotomy position

To the Editor:
We present our experience of the anesthetic management of patients in the rarely used prone lithotomy position (Figure).
During surgery, the prone position, if correctly applied, ensures free abdominal movement, is not associated with adverse effects on respiratory mechanics and improves lung volume and oxygenation.^{1,2} The lithotomy position, when superimposed on the prone position, improves cardiac output and hemodynamics, compensating for the decreased cardiac output due to impaired venous return in the prone position.³ Repair of a vesico-vaginal fistula under balanced anesthesia was performed in the prone lithotomy position in three ASA physical status I and II patients. In all cases, non-invasive blood pressure, central venous pressure (CVP), ECG, airway pressure, end tidal carbon dioxide and oxygen saturation were monitored and changes in hemodynamic and respiratory variables were recorded. After the change of position to prone lithotomy, all variables remained stable except for a rise in airway pressure in the range of +1 to +2 cm H₂O in one patient but without change in end tidal carbon dioxide tension and oxygen saturation. Another patient had a moderate rise of CVP (+2 to +5 cm H₂O). Peripheral nerve injury did not occur in any of the patients. The variables returned to baseline levels after patients were placed in the supine position after surgery, before extubation.

FIGURE Surgical repair of vesico-vaginal fistula in the prone lithotomy position.

On the basis of the experience gained during these three cases, we suggest that surgery in the prone lithotomy position is not associated with major cardiovascular or respiratory derangements intraoperatively.

Shashi Srivastava MD
Chandra Kant Pandey MD
Lucknow, India

References

1 Pelosi P, Croci M, Calappi E, et al. The prone positioning during general anesthesia minimally affects respiratory mechanics while improving functional residual capacity and increasing oxygen tension. *Anesth Analg* 1995; 80: 955–60.
2 Pelosi P, Croci M, Calappi E, et al. Prone positioning improves pulmonary function in obese patients during general anesthesia. *Anesth Analg* 1996; 83: 578–83.
3 Cucchiara RF, Ronal JF. Patient positioning. In: Miller RD (Ed). *Anesthesia*, 5 ed. New York: Churchill Livingstone Inc., 1999: 1017–32.
4 Thompson JD. Vesicovaginal and urethrovaginal fistula. In: Rock JA, Thompson JD (Ed). *Te Linde’s Operative Gynecology*, 8th ed. Philadelphia: Lippincott-Raven, 1997: 1175–1205.

Cost and resource implications of undergraduate simulator-based education

To the Editor:
Medical education has been recognized as a costly undertaking especially when innovations are introduced. Rothman and Cohen point out that standardized assessments like the Objective Structured Clinical Examinations (OSCE) are logistically complex and expensive.¹ Interest in the use of anesthesia simulators for both educational and assessment purposes has increased as more medical schools acquire this technology. However, issues related to the financial and faculty resources cannot be ignored.

TABLE Estimation of operational costs

Item	Annual cost (Cdn \$)	Cost per student (Cdn \$)
Simulator equipment and supplies	3,500.00	19.77
Computer operator	4,500.00	25.42
CO ₂ cylinders	300.00	1.69
Videotapes	180.00	1.02
Office equipment and supplies	324.00	1.83
Total	8,804.00	49.73