of ACE inhibitor angioedema. *Pharmacotherapy* 2002; 22: 1173–5.

- 6 Irons BK, Kumar A. Valsartan-induced angioedema. *Ann Pharmacother* 2003; 37: 1024–7.

Reply:

Thank you for the opportunity of replying to the letter of Dr. Adachi and colleagues.

Dr. Adachi and colleagues documented two cases of tongue edema in patients following cardiopulmonary bypass. Following exclusion of other possible precipitating causes, it was concluded that angioedema secondary to angiotensin converting enzyme inhibitor (ACEI) therapy was the most likely diagnosis. These two cases highlight some of the more interesting aspects of angioedema secondary to ACEI therapy discussed in our review.

Firstly, use of ACEI medication is increasing and clinicians will be faced with the complications of therapy. It is therefore important that they are aware of this potentially life threatening complication. Secondly, although theoretically angiotensin receptor blocker (ARB) drugs should not cause angioedema, these case reports emphasize that ARBs cannot be considered completely safe.^{1–3} Finally, it is unfortunate that there are no definitive symptoms or investigations to confirm the diagnosis which is based on a high index of suspicion and exclusion of other possible causes of angioedema. Clinical awareness of this potentially life threatening complication and prompt intervention remain the keys to successful management.

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- 2 Chiu AG, Krowiak EJ, Deeb ZE. Angioedema associated with angiotensin II receptor antagonists: challenging our knowledge of angioedema and its etiology. *Laryngoscope* 2001; 111: 1729–31.
- 3 Howes LG, Tran D. Can angiotensin receptor antagonists be used safely in patients with previous ACE inhibitor-induced angioedema? *Drug Saf* 2002; 25: 73–6.

Training pathways for perioperative transesophageal echocardiography

To the Editor:

We write in regards to the just-published Canadian guidelines for perioperative transesophageal echocardiography (TEE),¹ and the accompanying editorial.² We first of all wish to commend the group for creating the guidelines at all; that a clearly written document, supported by evidence where available, was produced by such a large number of authors is testimony to the effort and thought that went into the document. However, the recommendation that the basic level of proficiency be attained in a minimum of three months dedicated TEE training, with all studies completed within a year, is at odds with the understanding that adult learning be needs-based and individualized. The authors cite references supporting the minimum number of studies required, but they do not provide evidence for the timelines suggested, and for many centres reality will dictate that the basic level of proficiency will be achieved by people who will either combine clinical work with their practical TEE training, or will not provide the service at all.

The editorial states that the guidelines “extend the expected proficiency of an individual trained at the basic level to include limited diagnostic abilities [in recognition of] the expertise one would realistically expect of a specialist physician who undertakes three months of dedicated training in TEE”. However, the guidelines indicate that any abnormalities found require consultation with an advanced level practitioner if treatment will be significantly influenced. The reasoning behind the more demanding requirements for basic training then becomes circular. Put another way, if proficiency in TEE is thought of as a continuum from beginner, through basic, to advanced skills, perhaps the point at which the authoring group has elected to place the “basic skills” label is at the wrong point along the skill spectrum: far enough to make it difficult for any but academic centres to train practitioners, but not far enough to make them independent.

All but one of our present TEE practitioners created their own learning program, and most of the hands-on training was done locally. It requires considerable effort on the trainee's part, not to mention a great deal of support from our colleagues in anesthesiology and cardiology who have advanced skills, to develop one's abilities in this way. It is disappointing to have this route of training ignored by the guidelines, and the ramifications not addressed in the editorial. We