Correspondence

The GlideScope in current clinical practice

To the Editor:

Use of the GlideScope video laryngoscope (Verathon, Bothell, WA, USA) has increased endotracheal intubation success rates, reduced the time required to perform tracheal intubation, reduced the need for additional maneuvers, and reduced the potential for dental trauma [1]. The GlideScope has been proven to be useful both as a primary and a rescue device for difficult airway management in different patient populations: adult [2,3], pediatric [4], infant [5], and parturient [6].

The GlideScope has been used frequently in the management of potentially difficult airways and for teaching purposes. However, an important clinical issue was highlighted recently. Should all patients in whom a GlideScope is used be given a letter indicating such, regardless of circumstance and/or should all patients undergo one attempt at conventional laryngoscopy, before elective GlideScope use, to document the airway classification for future reference [7]?

We randomly surveyed 36 anesthesia practices in Florida. The practice names and telephone numbers were randomly selected from Florida Society of Anesthesiologists registered directories. The telephone call or email was directed to an anesthesiologist representing each anesthesia group. The questions included: Do you have video laryngoscope in your practice? and, What kind of video laryngoscope do you have?

All anesthesia practices answered the questions (100% response); 35 of 36 anesthesia practices (97%) had video laryngoscopes. The one practice (3%) that did not have this device provided anesthesia service for pediatric outpatient dental procedures. Among the 35 practices that were equipped with a video laryngoscope, 33 of 35 had the GlideScope, one had a McGrath laryngoscope (LMA North America, Inc., San Diego, CA, USA), and one practice had 1a Bullard laryngoscope (Gyrus Acmi, Inc., Norwalk, OH, USA).

The results of the study provide evidence that the majority of anesthesia practices have video laryngoscopes. Routine use of the GlideScope has become more prevalent, not only in teaching hospitals, but also in most private practices. Furthermore, the learning curve for the video laryngoscopes is short [2,8].

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References


Is this complex regional pain syndrome or reflex sympathetic dystrophy?

To the Editor:

Although “pain” is regarded as the sine qua non of complex regional pain syndrome (CRPS), reports of painless CRPS do exist [1]. A 50 year old woman sustained fractures at her left elbow and wrist, which were surgically fixed and immobilized with a cast for 45 days. Subsequently she developed rigidity with difficulty in extension. A referral to physiotherapy was
made by the surgeon, who did not explain the diagnosis of CRPS to the patient. She noticed other changes, including swelling of her hand, increased hair growth, fingers turning blue, increased sweating, and increased rigidity.

A second consultant believed that she did not have CRPS because she did not have pain. When we evaluated her 4 months after the injury, we noticed clear changes of swelling, shining skin, increased hair and nail growth, early clubbing, and atrophy of her medial group and hypothenar muscles. Surprisingly conspicuous was the absence of pain throughout the disease course!

The clinical entity of CRPS still remains incompletely understood. The uncertainty of diagnosis is reflected by the varied nomenclature; the English and Dutch literature combined account for 93 different names for reflex sympathetic dystrophy (RSD) [2]. Although it is presently recognized as CRPS and is diagnosed as per International Association for the Study of Pain (IASP) criteria [3], even these criteria are widely acknowledged to be suboptimal [4]. The IASP criteria were modified recently after observations in validation studies showed them to cause over-diagnosis [5]. Vasomotor symptoms, changes in range of motion, and trophic changes are now considered as separate factors [5]. However, pain remains as the most essential criterion. Painless CRPS was reported earlier by Eisenberg and Melamed, who suggested the term, “complex regional painless syndrome” (CRPLS) [1]. It is noticeable that 4 of these patients had plastic-cast immobilization similar to the current case. Veldman et al reported 7 cases in their study of 829 patients [6]. Pathophysiology of this unique disorder involves the autonomic system apart from pain pathways, with newer evidence pointing to hypoxia, infection, inflammation, and neuropeptides as the inciting events [7].

Sympathectomy is used in CRPS to relieve pain and also to reset the abnormally active sympathetic component. Although the evidence for sympathectomy in CRPS is not fully supportive [8], it was noted that the motor/trophic factors predicted positive responses to sympathectomy block (P < 0.05), in the external validation studies [5]. The lack of pain, as in this case, makes it more difficult to apply treatments targeted at sympathetically mediated pain. If the treatment of CRPS is to be advanced, clinical research must address ways of improving recognition and diagnosis of the disorder.

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References


Atrial fibrillation during veno-venous bypass for orthotopic liver transplantation

To the Editor:

A patient developed atrial fibrillation (AF) with rapid ventricular response after initiation of veno-venous bypass (VVBP). The arrhythmia was refractory to pharmacologic intervention and resolved only with termination of bypass.

A 64-year-old woman with a body mass index of 19 kg/m² presented for orthotopic liver transplantation (OLT) for hepatitis C cirrhosis and hepatocellular carcinoma. Her Model End-Stage Liver Disease score was 29. Other medical problems included Mycobacterium avium-intracellularare, osteoporosis, and several hospitalizations for gastrointestinal bleeds secondary to grade 3 gastric varices. Her past surgical history included transcatheter arterial chemoembolization, open reduction internal fixation of the left femur, rhytidectomy, bilateral breast augmentation, and colonoscopies, all without complication. Her home medications included furosemide, spironolactone, pantoprazole, nadolol, ethambutol, azithromycin, and rifampin, as well as multiple supplements including L-glutamine, L-glutathione, coenzyme Q10, N-acetylcysteine, alpha lipoic acid, Arsenicum album, Ribis nigrum, milk thistle, and grape seed extract. She had no known drug allergies. She had smoked one to three packs of cigarettes per day for 8 years, but quit 30 years ago. She did not drink alcohol and denied illicit drug use.