To the Editor:—I read with considerable interest the article by Benavides et al.1 describing experiments of air bubble growth in water during exposure to 100% nitrous oxide, 100% xenon, or 50% xenon-50% oxygen. Although the experiments were nicely conducted, they explore a physics of gas flux in an unconstrained bubble permitted to grow spherically. Importantly, this geometry has limited biologic relevance for bubbles occluding vessels in the size range they have studied. The authors have referenced our previous work on xenon transport,2 but they have mistakenly interpreted the findings presented therein to indicate the growth of bubbles as spheres. Rather, that study presents some simulations for bubbles that are initially spherical and just fill the vessel lumen. Such bubbles cannot grow radially because they are constrained by the vessel wall and therefore elongate during growth while maintaining a fixed curvature on the interface. This results in a much different force balance across the gas-liquid interface and, hence, a different pressure condition on the interior of the bubble from that which occurs in the case of a time-varying interface shape, which the authors have studied. We have described these differences in our previous theoretical and experimental studies of intravascular gas embolism.2–5

In addition, the initial internal gas content they have studied includes nitrogen, equilibrated with test solution A, but test solution B is nitrogen free. Hence, there are large gradients for nitrogen flux when the solutions are switched. We purposely avoided nitrogen as a component of either the bubble or perfusate in our predictions and considered only oxygen and xenon as the transportable species.2 Whereas others have studied growth of similarly unconstrained air bubbles during cardiopulmonary bypass,6 our work has not provided any data for direct comparisons such as the authors have made, based on the different gas constituents and the governing physics dictated by the shape constraint.

I find it fascinating, however, that they have couched their results in terms of bubble diameter growth. When transferred to the volume domain, one readily sees that the spherical bubbles exposed to 100% xenon or 100% nitrous oxide had grown to more than twice their initial volume in 25 min (figs. 2 and 3) and continued growing when the solutions were switched (downward arrow). The time required for this is surprisingly similar to the volume doubling times we reported for many of the cases we explored, despite the differences in our model and these experiments.

The curve fitting by a double exponential suggests that there will be continuous exponential growth of bubble diameter. So although the physics and gas transport are different from what we studied, the indication of the studies are the same.

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increase in the number of observed emboli, which would have oc-

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To the Editor:—I read with interest the report by Campos et al. This article reported 39% and 36% incidences of failure of proper placement of lung isolation devices by faculty and senior residents, respectively. All participating anesthesiologists did not regularly practice thoracic anesthesia. The authors stated that one-lung ventilation is primarily provided by either a double-lumen tube, the Univent® torque control blocker (VitaId Ltd., Lewiston, NY), or the Arndt® blocker (Cook Critical Care, Bloomington, IN). However, an additional blocker that was not mentioned is the Cohen blocker (Cook Critical Care). This commonly used blocker has a wheel at the operator end that, when turned, flexes the tip and gives the anesthesiologist the ability to direct the blocker to the appropriate bronchus.

This is an important article that highlights the difficulties for anesthesiologists who need to provide one-lung ventilation on an occasional basis. There is a learning curve with all of these techniques. I agree with the authors that the successful practice of thoracic anesthesia requires familiarity with the devices, skill in fiberoptic bronchoscopy, and knowledge of the tracheobronchial anatomy. Residents learning thoracic anesthesia should learn all three of these types of skills before graduation, and these should be specific goals in residency programs.

The authors stated that the preoperative instruction included the fiberoptic views that constituted correct positioning of the device. When checking the position of the lung isolating device, it is also important to identify the right upper lobe, the characteristic D-shaped opening to the middle lobe, and the basilar and superior segments of the lower lobe. The left mainstem bronchus is identified, as well as the left upper and left lower lobes. The views of just the double-lumen tube or blocker balloon are not adequate for establishing correct positioning, which could account for some of the malpositions reported in the study. If a simplified instruction is given, it is most important to identify the right upper lobe. It would be helpful to know exactly which views were included in the tutorial.

It would be interesting to repeat the study, with more training, to achieve a higher success rate. Anesthesiologists who may have to provide one-lung ventilation on occasion should become familiar with the devices, learn the tracheobronchial anatomy, and practice fiberoptic bronchoscopy. There are hands-on workshops that are given at the annual meetings of the American Society of Anesthesiologists and the International Anesthesia Research Society and at the PostGraduate Assembly in Anesthesiology.

When choosing a lung isolation technique, there are other issues to consider besides the initial placement. Blockers, especially when used on the right side, are more easily dislodged than double-lumen tubes. It is also easier to suction and apply oxygen via a double-lumen tube, compared with a blocker. The main advantage of the blocker is in the patient with the difficult airway, which was excluded in the study. It is essential to be knowledgeable of possible complications. For example, a blocker may become dislodged into the trachea and block ventilation completely. Techniques for prevention and treatment of hypoxemia must be understood.

There is more to practicing thoracic anesthesia than just the initial placement of the lung isolation device.

The most important teaching message from this study is that practitioners who may have to provide one-lung ventilation on an occasional basis need to do continuing medical education. Development of a tutorial and/or attending a hands-on workshop might be beneficial.

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Reference


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After we published our study, we designed a second study based on the tracheobronchial anatomy and skills in fiberoptic bronchoscopy. In fact, anesthesiologists in lung isolation techniques, with particular emphasis on double-lumen endotracheal tubes and bronchial blockers (Univent® [Vitaid Ltd., Lewiston, NY] and Arndt® [Cook Critical Care, Bloomington, IN] blocker) and because the most common device used for lung isolation is the left-sided double-lumen endotracheal tube, we are currently conducting a new study, involving the use of left-sided double-lumen endotracheal tubes among anesthesiologists with limited experience in thoracic anesthesia (i.e., less than two lung isolation device cases per month). In this randomized study, one group of anesthesiologists has been assigned to a tutorial in the simulator facility at The University of Iowa (Iowa City, Iowa), providing a tutorial demonstration and hands-on practice in proper placement of a double-lumen endotracheal tube with the aid of flexible fiberoptic bronchoscopy techniques on a mannequin model. The second group has been assigned to self-training using a DVD that was made by one of the authors (J.H.C.) that includes placement of left-sided double-lumen endotracheal tubes along with a detailed description of fiberoptic bronchoscopy techniques. It is our hope to have a definitive answer to determine which method (simulator training vs. DVD self-training) facilitates placement of double-lumen endotracheal tubes for anesthesiologists with limited thoracic anesthesia experience.

Our study has shown that one of the limitations of anesthesiologists with limited experience in thoracic anesthesia is unfamiliarity with bronchial anatomy. In principle, every anesthesiologist resident or staff member should know the anatomical distances pertaining to the airway; for example, in an average subject, the distance from the incisors to the vocal cords is 15 cm, and the distance from the vocal cords to the tracheal carina is approximately 12 cm. The distance from the tracheal carina to the takeoff of the right upper lobe bronchus is an average of 1.5 cm in females and 2 cm in males. The distances from the carina to the takeoff of the left upper and left lower bronchi are an average of 4.5 and 5.0 cm, respectively.

Furthermore, when looking through the fiberoptic bronchoscope, the only early structure in the right mainstem bronchus that has three orifices is the right upper lobe bronchus: These are the apical, the anterior and the posterior bronchi. If every anesthesiologist recognized this anatomical structure, fewer problems would be encountered when inserting lung isolation devices. Adding a shared demonstration through a video-bronchoscopy might enhance training. Unfortunately, it has not been scientifically tested.

In response to Dr. Ng’s letter, we fully agree with his comments that more attention should be given while training residents or staff anesthesiologists in lung isolation techniques, with particular emphasis on tracheobronchial anatomy and skills in fiberoptic bronchoscopy. In fact, after we published our study, we designed a second study based on the lessons that we learned previously. Because the previous study did not demonstrate any advantage between the left-sided double-lumen endotracheal tubes and bronchial blockers (Univent® [Vitaid Ltd., Lewiston, NY] and Arndt® [Cook Critical Care, Bloomington, IN] blocker) and because the most common device used for lung isolation is the left-sided double-lumen endotracheal tube, we are currently conducting a new study, involving the use of left-sided double-lumen endotracheal tubes among anesthesiologists with limited experience in thoracic anesthesia (i.e., less than two lung isolation device cases per month). In this randomized study, one group of anesthesiologists has been assigned to a tutorial in the simulator facility at The University of Iowa (Iowa City, Iowa), providing a tutorial demonstration and hands-on practice in proper placement of a double-lumen endotracheal tube with the aid of flexible fiberoptic bronchoscopy techniques on a mannequin model. The second group has been assigned to self-training using a DVD that was made by one of the authors (J.H.C.) that includes placement of left-sided double-lumen endotracheal tubes along with a detailed description of fiberoptic bronchoscopy techniques. It is our hope to have a definitive answer to determine which method (simulator training vs. DVD self-training) facilitates placement of double-lumen endotracheal tubes for anesthesiologists with limited thoracic anesthesia experience.

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number of malpositions was quite low for both tube types and did not differ between the groups. Therefore, the choice of device for lung isolation in the right mainstem bronchus does not matter when a cardiothoracic anesthesiologist places these devices. This concept might not apply to anesthesiologists with limited experience in thoracic anesthesia, but to our knowledge, this has not been tested scientifically.

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Ambesh Maneuver during Subclavian Vein Catheterization Successfully Prevents and Detects Misplacement of the Catheter into Ipsilateral Internal Jugular Vein

To the Editor.—During subclavian vein catheterization, one of the most common malplacements of the catheter is into the ipsilateral internal jugular vein (IJV). Chest radiography is performed to identify the exact location of the catheter and procedure-related complications.1 Misplaced catheters have increased risks of thrombophlebitis in addition to impairment of the central venous pressure (CVP) measurement.2 Recently, Ambesh et al.3-4 showed that manual occlusion of the ipsilateral IJV in the supraclavicular fossa during and after insertion of subclavian vein catheter is successful in preventing and diagnosing the misplacement of the subclavian vein catheter into the IJV. Since Ambesh et al. developed this maneuver and reported excellent results, no other study has validated these results. Therefore, in a randomized and controlled study, we tested whether the Ambesh maneuver is successful in preventing and diagnosing the misplacement of a subclavian vein catheter into the IJV.

After approval by the Ethics Committee (King George’s Medical University, Lucknow, India), 300 adult patients of either sex scheduled to undergo central venous cannulation through the subclavian approach were randomly allocated into two groups of 150 each. Informed verbal consent was obtained from all patients before the procedure. In a patient lying supine with a 15°-20° Trendelenburg position and the head turned to the left, the junction of the medial one third and lateral two thirds of the clavicle in the right infraclavicular area was chosen as the puncture point. An 18-gauge introducer needle was inserted at this point and directed toward the sternoclavicular joint. After free flow of venous blood, the J-tip guide wire was threaded through the cannula into the subclavian vein. In the Ambesh maneuver group of patients, the ipsilateral IJV was occluded, as described by Ambesh et al.,3 during threading of the J guide wire, whereas in control group, no such maneuver was performed. The subclavian vein catheter was then railroaded over the guide wire. The catheter was then connected with a transducer, and the CVP value and waveform pattern were observed. Next, the Ambesh maneuver† was reapplied for approximately 10 s, and changes in CVP value and waveform pattern were noted. If there was an increase in CVP value by more than 3 cm H2O along with flattening of the waveform, it was presumed that the catheter tip was misplaced into the ipsilateral IJV. At the end of the procedure, chest radiography was performed, and position of the catheter was identified in all patients. The characteristics of the patients were analyzed using the Student t test and Fisher exact test. P values were two-tailed, and P > 0.05 was considered significant.

The age, sex, and body weight of the patients were comparable in two groups. Five patients in the control group and 7 patients in the Ambesh maneuver group could not be cannulated; therefore, 145 patients in the control group and 143 patients in the Ambesh maneuver group were analyzed. Chest x-ray films showed that in control group, there were 10 (6.9%) misplaced catheters, 9 (6.2%) in ipsilateral IJV and 1 (0.7%) in opposite subclavian vein, whereas in the Ambesh maneuver group, there were 2 (1.4%) (95% confidence interval, 1.4-6.9%; P < 0.05) misplaced catheters, both in the opposite subclavian vein and none in the IJV. The operator experienced difficulty in inserting the guide wire in 3 patients of control group and 9 patients of Ambesh maneuver group. The withdrawal and reinsertion of the guide wire and catheter were easy.

The correct placement of the central venous catheter is an essential prerequisite for accurate monitoring of CVP and long-term use of the catheter. Misplacement of the tip may enhance the risk of clot formation, thrombophlebitis, and catheter erosion in addition to impaired CVP measurement.2,5 Recently, Domino et al.6 reported that the proportion of malpractice claims related to central catheters and vascular access injury has increased significantly. The incidence of malpositioning of CVP catheters through the infraclavicular technique of the subclavian vein varies between 4% and 8%.3-5 Our study shows a 6.9% incidence of malplacement of subclavian vein catheter through the right infraclavicular approach, and most of the misplacements were in the ipsilateral IJV (6.2%). The operator encountered difficulty in insertion of the guide wire in only 3 patients without IJV occlusion and in 9 patients with IJV occlusion. It becomes obvious that the guide wire in some of these 9 patients of the IJV occlusion group was intending to go into the ipsilateral IJV, but the IJV was occluded manually. The occlusion of ipsilateral IJV in the supraclavicular area may have prevented the cephalad insertion of the guide wire and therefore the subclavian vein catheter into the IJV.

We conclude that the Ambesh maneuver is a simple, inexpensive, and handy bedside technique that helps in preventing and diagnosing the misplacement of a subclavian vein catheter into the IJV. We strongly believe that the Ambesh maneuver should be used in all patients undergoing subclavian vein catheterization.

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To the Editor—American inventor and businessman Thomas Alva Edison is legendary for his contributions to such technologies as the lightbulb, the telephone, the phonograph, and motion pictures, among many others. In his lifetime, Edison obtained 1,093 US patents and some 1,239 patents in other countries. Little known among these efforts was his “improved anesthetic compound.”

In the summer of 1882, George F. Shrady (Founder and Editor, Medical Record 1866–1904) (1837–1907), reported that Thomas Edison invented a new anesthetic made of chloroform, ether, alcohol, and camphor and had applied for British and German patents. The witty but misinformed editor added, “Edison may wish to use it on his stockholders until electric light was in successful operation.”

In fact, the “anesthetic” actually was an analgesic liniment that Edison had prepared in early 1878. He named it Polyform and advertised it for “neurologic pain.” Polyform was a mixture of chloroform, ether, camphor gum, alcohol, chloral hydrate, morphine, and oils of peppermint and clove. Edison believed that his compound’s various analgesics would potentiate each other and that the mixture would attack pain in a “shotgun manner.”

In 1879, Edison applied for a US patent but, for unknown reasons, withdrew his application shortly thereafter. In February 1880, the British patent No. 599 was granted to his London agents for a slightly modified compound. The editor of the Medical Record was misinformed: Edison did not apply for a German patent (written personal communication, Hubert Rothe, Director, Information Department, German Patent and Trademark Office, Munich, Germany, May 2004).

Topical ether and, especially, chloroform had been widely used for musculoskeletal and neurologic pains since their discovery. At the time of Edison’s invention, not only were liniments of chloroform and of camphor used in the United States, but there also existed lotions made of chloroform, camphor, ether, alcohol, morphine, and chloral hydrate. One, Sankt Jakob Oel, had been popular in Germany since the mid-1870s. It was marketed in the United States during the 1880s under the name of St. Jacob’s Oil by the firms of C.A. Voegeler in Baltimore and Kroeger Ltd. of Cincinnati. Its formula is given in several US formularies.

Whether Edison knew of St. Jacob’s Oil when he invented his Polyform or whether he learned of its existence later on is unknown. The latter may explain why he did not apply for a German patent and withdrew his US application.

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We report a case of acute upper gastrointestinal bleeding from mucosal tears resulting from gastric overdistention after inadvertent esophageal intubation. To our knowledge, this complication has not been previously described and should be included in the differential diagnosis of upper gastrointestinal bleeding in critically ill patients who have had inadvertent esophageal intubation or cardiopulmonary resuscitation. The combination of history of esophageal intubation, involvement of the lesser curvature, and similarity to the mucosal tears seen by Green and Tendler during percutaneous endoscopic gastrostomy tube placement support this diagnosis. In addition, in cases of upper gastrointestinal bleeding when a history of inadvertent esophageal intubation is obtained, gastric perforation should be ruled out with abdominal imaging before performing upper endoscopy.

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Anesthesia in a Patient with Gitelman Syndrome

To the Editor.—We would like to report our recent experience with a patient with a rare disorder known as Gitelman syndrome.

Gitelman syndrome, a variant of Bartter syndrome, is a congenital autosomal recessive disorder characterized by hypokalemia, hypomagnesemia, and hypocalcinuria associated with metabolic alkalosis. Unlike Bartter syndrome, which presents in the neonatal period and childhood up to 5 yr of age, Gitelman syndrome presents in early adulthood. The two syndromes may also be distinguished from each other because Gitelman syndrome presents with hypomagnesemia and hypocalcinuria, whereas Bartter syndrome presents with normal serum magnesium and high urinary calcium. Patients with Gitelman syndrome usually present with cramps, fatigue, muscle weakness, and carpopedal spasms.

A 47-yr-old woman recently presented to us for repair of nasolacrimal duct stenosis during general anesthesia. Her medical history was significant for diabetes, gastrointestinal reflux disease, and thyroid disease. Her surgical history included a hysterectomy, an appendectomy, a thyroidectomy, a breast biopsy, and an exploratory laparotomy for ovarian cancer. She described her symptoms as cramps in her legs. She related that 2 yr ago during the surgery for her thyroid, she had a cardiac arrest. The patient stated that her cardiac arrest had occurred because of unrecognized hypokalemia and hypomagnesium.

Her medications included potassium chloride, magnesium, spironolactone, levophylxine, gliburide, and lensoprazole. Her vital signs included a blood pressure of 111/77 mmHg, pulse of 98 beats/min, respiration of 18 breaths/min, and temperature of 97.9°F. Her laboratory studies showed the following: white blood cells, 10.6 (4.1–11.2); hemoglobin, 15.3 g/dl (11.5–15.1); hematocrit, 45.0% (35–46); platelets, 503 × 1003 (140–400); Na, 137 mEq/l (136–145); K, 4.2 mEq/l (3.5–5.1); Cl, 96 mEq/l (98–107); HCO3-, 27 (20–27); blood urea nitrogen, 20 mg/dl (6–20); creatinine, 0.8 (0.5–1.2); glucose, 68 mg/dl (65–115); Ca, 10.9 mEq/l (8.8–10.5); Mg, 1.9 mEq/l (1.3–2.1); and urine creatinine, 181 mEq/l. She was 4 ft 11 in tall and weighed 70 kg.

In the operating room after placement of an electrocardiograph, noninvasive blood pressure cuff, and pulse oximetry, general anesthesia was induced using propofol and fentanyl with rocuronium for muscle relaxation and for tracheal intubation. Desflurane was used...
for maintenance of anesthesia. At the end of the case, the muscle relaxant was reversed using glycopyrrolate and neostigmine. When the patient was awake and responding to commands, her trachea was extubated in the operating room without any complications.

Although the patient’s current magnesium level was only slightly decreased, we decided not to replace it. Her current potassium level was also normal. She was aware of her diagnosis of Gitelman syndrome and was taking potassium and magnesium replacement. Review of the literature reveals that ventricular tachycardia has occurred in patients with Gitelman syndrome when potassium and magnesium levels are low. This potentially fatal arrhythmia must be recognized and treated early.

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