techniques hinder comparison of results obtained by orthogonal polarization spectral versus side-stream dark-field imaging and may explain the differential results. Second, the authors used software to measure microvascular diameter, erythrocyte velocity, and functional capillary density. In our study, a semiquantitative analysis technique was used. Although software can be helpful in decreasing the burden of a time-consum ing semiquantitative analysis, we have to look critically at the numbers produced by the software. For example, we would like to learn from the authors whether it was possible to measure erythrocyte velocity in each investigated capillary and venule. Using Microscan Analysis Software (MicroVisionMedical, Inc., Amsterdam, The Netherlands), we experienced that it was impossible to measure high erythrocyte velocities that do exist in a substantial number of capillaries. This problem is probably due to a limited video frame rate: 25 frames/s for phase alternating line standard. Finally, several issues remain unclear after reading the authors’ article. The inclusion criteria used by the authors are not exactly mentioned. Did the authors investigate consecutive, low-risk patients? What was the estimated risk of surgery for the patient population (logistic European System for Cardiac Operative Risk Evaluation [EuroSCORE])? What were the incidences of postoperative morbidity and mortality? We think it might be interesting to investigate a possible relation between intraoperative hypoperfusion of the microcirculation and postoperative outcome. This might be studied in a subgroup of patients with impaired functional capillary density during cardiopulmonary bypass. In addition to this, we wonder why the authors did not separate venules from capillaries, using a cutoff of 20 μm.

To conclude, it is of interest to note that both studies reported moderate changes in the sublingual microcirculation that probably reflect a complex pathophysiology during cardiopulmonary bypass. It is expected that novel bedside imaging technology will simplify further microcirculation research in patients based on studies that were performed previously in laboratory animals.5,4 We should focus on the questions of which individual stimuli are responsible for the reported changes and whether these changes are of clinical significance. Larger studies, perhaps in high-risk patients, will be helpful to draw stronger conclusions.

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(Accepted for publication April 22, 2008.)
To the Editor—A 70-yr-old woman undergoing back surgery was intubated without difficulty using the light-guided Trachlight lightwand device (Laerdal Medical, Stavanger, Norway), which we use for routine intubations in our operating room. She was then placed in a prone position, with her head held with a ProneView® Protective Helmet System (Dupaco, Oceanside, CA). A gastric tube was placed transorally. At the end of the operation, we found a white, 2-mm³, plastic fragment on the tip of her head held with a ProneView® Protective Helmet System (Dupaco, Oceanside, CA). A gastric tube was placed transorally. At the end of the operation, the patient being fully awake and asymptomatic when we first realized that another fragment was missing, we chose to observe her and abstained from undertaking major investigations, such as tracheal endoscopy or computed tomography.

The rail gear fragment probably broke off when the wand was withdrawn from the endotracheal tube. Because we found a single fragment and the rail was missing two teeth, the other fragment might have fallen into the trachea through the endotracheal tube. The patient being fully awake and asymptomatic when we first realized that another fragment was missing, we chose to observe her and abstained from undertaking major investigations, such as tracheal endoscopy or computed tomography.

Support was provided solely from institutional and/or departmental sources. The authors have no conflict of interest to disclose.

References


Fig. 1. (4) Trachlight lightwand device (Laerdal Medical, Stavanger, Norway) with endotracheal tube. (B) Trachlight handle and fragmented part of the handle rail gear. Two teeth are missing from the distal handle (double black arrows). The arrowhead points to the retrieved rail gear fragment.

To the best of our knowledge, this is the first report of a potential complication from a rail chipping during the manipulation of a Trachlight intubation device.

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(Accepted for publication April 16, 2008.)