

with 40 to 50 degree and could be changed by the assistants according to the requirement of the operators.

The enrollment of the optimal external laryngeal manipulation to improve laryngeal views was required in some cases of both groups. We agree that the placement of the flashlight (Fenixlight Limited, Shenzhen, China) itself may have a positive effect on the exposure of the glottis compared the patient without any external laryngeal manipulation in direct laryngoscopy group.

As regards the letter from Dr. Cherng, we agree as noted above that placement of the flashlight and any pressure applied could have altered or improved exposure of the glottis.

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Applying Systematic Criteria for Type and Screen Based on Procedure's Probability of Erythrocyte Transfusion

To the Editor:

Frank *et al.*¹ describe development of a maximum surgical blood ordering schedule. We are pleased that they used our findings² regarding choice of whether to perform Type and Screen preoperatively. From the authors:¹

"Using previously proposed criteria, we developed an algorithm ... to determine the appropriate preoperative blood order for each procedure category. These criteria included: 5% or more of patients transfused with erythrocytes²; median estimated blood loss (EBL) more than 50 ml²; and a transfusion index 0.3 or more."

Although the reliability and validity of the first two of the criteria refer to our article,^{1,2} our table 1 summary of our Results was different:

"Select a threshold for 'minimal EBL' (e.g., 50 ml) by using the smallest median EBL with many scheduled procedures and cases for which the lower 95% confidence limit for the incidence of erythrocyte transfusion was more than 5.0% ... For each of the scheduled procedures with median EBL ... less than [this] threshold ... calculate the lower 95% confidence

limit for the incidence of transfusion ... For each of the scheduled procedures for which the calculated value ... is less than 5.0% and for which there are 19 or more cases, set the MSBOS to indicate no type and screen."

Thus, the value of 50 ml was to be determined statistically for each hospital; our criterion was less than 50 ml not larger than 50 ml; and we did not use 5% but the lower confidence limit of 5%. The criterion of less than 50 ml *versus* larger than 50 ml had a substantive effect at our studied hospital because the EBL often were reported using rounded values (e.g., not 49 ml but 50 ml).² If the authors¹ apply the criteria that we published, are any of their hospital's maximum surgical blood ordering schedule recommendations changed?

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2. Dexter F, Ledolter J, Davis E, Witkowski TA, Herman JH, Epstein RH: Systematic criteria for type and screen based on procedure's probability of erythrocyte transfusion. *ANESTHESIOLOGY* 2012; 116:768–78

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In Reply:

I appreciate the comments by Dexter and Epstein regarding our publication on optimizing preoperative blood ordering.¹ In their comment, they pose the question of whether our recommended maximum surgical blood order schedule would be changed if we applied the criteria published in their own study.²

The answer is that I do not know whether our recommendations would be changed because Dexter and Epstein's methods are somewhat complicated and difficult to understand. Our primary goal was to develop an algorithm that was simple and easy for other institutions to apply using their own data from an anesthesia information management system. In addition, I believe that our methods are more reliable because our algorithm does not rely as heavily on estimated blood loss (EBL), a parameter that most clinicians recognize as a crude measure that is fraught with error. In our algorithm, EBL was complimented by two other measures—percentage of patients receiving erythrocyte transfusion and the average number of erythrocyte units per patient—two variables that are much more objective and easy to determine from electronic anesthesia records.