For these reasons, we believe that fluid expansion must be interpreted with regard to the evolution of SV and HR. It might also be useful to standardize the definition of fluid responsiveness to allow comparisons between studies that use preload indices.

**Declaration of interest**

None declared.

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doi:10.1093/bja/aeu478

**Posture at laryngoscopy**

Editor—The article by H.-C. Lee and colleagues is of interest to me as a teacher of trainee anaesthetists. It is a well-known fact that novice anaesthetists tend to stoop, straining their back, and look closely in the mouth, thus making visualization of the glottis more difficult (because of reduced binocular vision). Matthews and colleagues stated in 1998 that ‘One anaesthetist commented that he tells students that they need only to look in the mouth, not get into it’, and conclude that ‘We now teach students explicitly to try to stand up and stand back when attempting intubation’. Walker’s conclusion in 2002 is that ‘Novice anaesthetists should be given explicit instructions on correct trolley height and should be taught to intubate with a straight back’. I give similar advice in my book, based on years of experience.

It seems that collective memory needs reiteration with each new generation of anaesthetists.

**Declaration of interest**

I am a published author of a book on airway management (cited).

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**Dynamic optimization of height relation between anaesthetist’s chest and patient’s face during tracheal intubation**

Editor—In a randomized controlled clinical trial assessing the influence of different operating table heights on the quality of laryngeal view and the discomfort of the anaesthetist during tracheal intubation, Lee and colleagues show that higher operating tables provide better laryngeal views with less discomfort during tracheal intubation. Their results provide robust evidence for a suggestion regarding the operating table height during tracheal intubation in the textbook of airway management; the height of the operating table surface should be adjusted to the level of the anaesthetist’s chest.

However, the findings of this study may be suitable only for the situation in which tracheal intubation is performed by the anaesthetist standing at the head of the patient. Moreover, the anatomy and biomechanics of the head and neck differ significantly among patients and change differently in response to head and neck positioning during laryngoscopy and tracheal intubation, especially for patients in whom intubation is difficult. This means that an operating table height cannot guarantee adequate laryngeal exposure in all patients, and fresh adjustment of the height relation between anaesthetist’s chest and the patient’s face may be required in order to obtain the best laryngeal view and the operator’s comfort. In addition, after tracheal intubation, it is also necessary to readjust the operating table height for surgical requirements.