pericardium, or both during cardiac or thoracic surgery modifies heart–lung interaction making ΔPP useless for predicting fluid responsiveness.5 Hence, care should be taken if tidal volume is decreased (in all major surgeries?), during laparoscopic surgery and during thoracic and cardiac surgery. As we emphasized in our article,1 ΔPP limitations should be known and checked before using this parameter not only in ICU but also in OT.

Declaration of interest
None declared.

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Making bisoprolol a perioperative agent
Editor—We read with great interest the recent editorial by Foex and Sear1 and applaud their comprehensive review on β-blockers and cardiac protection. These medications have significant anaesthetic implications for the providers as the patients taking them are already at higher risk for any surgical procedures.

According to the authors, while metoprolol appears to be inferior to atenolol in protecting high-risk patients, bisoprolol is likely to become the preferred drug of choice in the future as it provides better protection. Their analysis of 14 studies (n=1298 patients) showed that a single-dose treatment was effective in reducing perioperative myocardial infarction (odds ratio 0.17) and myocardial ischaemia (odds ratio 0.22). These treatments were not associated with significant hypotension or bradycardia. We agree with their recommendations that the initiation of β-blockers in patients who will undergo non-cardiac surgery should not be considered routine, but carefully considered on a case-by-case basis.

In a recent article, Ashes and colleagues2 also found that selective β-blockade with bisoprolol was associated with a decrease in the incidence of postoperative strokes when compared with atenolol and metoprolol.

In addition to the details of preoperative use of β-blockers, another consideration for the anaesthesia provider is what agent to administer during surgery when their arterial pressure, heart rate, or both increase to alarming heights, especially patients with pre-existing coronary artery disease since atenolol, metoprolol, and bisoprolol only come in a pill form. In terms of i.v. β-blockers to combat hypertension and tachycardia, the two commonly used agents come to mind: esmolol, which has fast onset, but short duration, and labetolol, which takes a bit longer to act, but lasts longer. With the recent evidence on bisoprolol offering better protection, more research should be directed at development of bisoprolol as an i.v. form.

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1 Foex P, Sear JW. β-Blockers and cardiac protection: 5 yr on from POISE. Br J Anaesth 2014; 112: 206–10

Benefits of continuous capnography monitoring for intensive care patients significantly outweigh any risks
Editor—We read with interest the letter by Dr Kingston and Dr Loh.3 Although the authors ascribe the clinical problem to the capnography line, it would be interesting to know whether the incident was detected more quickly because of it and whether adverse sequelae (such as those identified in NAP4) were averted. In our hospital, we have been using continuous capnography monitoring for all ventilated patients on our intensive care unit (ICU) for more than 5 yr. NAP4 showed that 70% of airway-related complications (and deaths) on ICU could have been prevented by the use of such monitoring for all patients reliant on an artificial airway.1–3 As the authors point out, education of ICU staff is essential, and we, like many ICUs, run training programmes for both the use and interpretation of capnography traces.6 The authors are right to highlight the risk of the capnography tubing running in the opposite direction to the ventilator