Accreditation in transoesophageal echocardiography

Editor—It is with interest that we read the current controversy regarding credentialling in perioperative transoesophageal echocardiography (TOE) in the UK.1,2 As experienced transoesophageal echocardiography (TOE) practitioners and newly endowed ‘Testamurs’ who have practised cardiac anaesthesia and actively trained numerous practitioners in TOE for more than 5 yr each, and who have now moved to non-cardiac anaesthesia and intensive care medicine where we continue to offer valuable TOE services, we wish to offer our perspective on the current accreditation controversy.

In the USA, the National Board of Echocardiography (NBE) recently introduced a programme of Board Certification in Transoesophageal Echocardiography and candidates who passed the TOE examinations administered by the NBE are now no longer considered to be TOE-certified, but are instead described as NBE-PTE ‘Testamurs’ (passed the NBE exam but not board certified).3,4 Although a ‘grandfather’ pathway to Board Certification currently exists (through proof of having completed fellowship training in cardiovascular anaesthesia), we believe that physicians in positions similar to ours who are now involved predominantly in non-cardiac practice would find it hard to meet the required diversity and required number of cases per year to maintain credentials after the first wave of credentialling, scheduled for 2008. Other TOE practitioners within non-cardiac anaesthesia and intensive care medicine who have not completed fellowship training in cardiovascular anaesthesia are unlikely to qualify for Board Certification in Transoesophageal Echocardiography as it is implemented this year, based on the requirement of 150 patients per year in the 2 yr immediately preceding their application.3,4 Furthermore, it is probably only a matter of time before those with testamur status will be denied clinical privileges, reimbursement and so on. Have we been disenfranchised?5 We think so. Unless provision is made for those not actively engaged in cardiac practice, we believe that a valuable intraoperative monitoring and diagnostic tool that is relatively non-invasive and highly effective in clinical decision making will be forced out of the hands of non-cardiac anaesthesia and intensive care medicine personnel. It will be reserved for a select group of individuals practising cardiac anaesthesia, to the detriment of non-cardiac surgical and critically ill patients.

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investigation. In most UK hospitals at present this expensive equipment is readily available only in the cardiac arena. There will inevitably be discussions with the Intensive Care Society and the accident and emergency fraternity to incorporate their needs into this evolutionary accreditation process.

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Hypertension and perioperative risk

Editor—I read the review1 and associated editorial2 about hypertension with considerable interest and was informed and educated by both. However, my concerns regarding preoperative hypertension do not only extend to the patient, but also to me!

Thus, for a risk-averse anaesthetist, the presence on the list of a patient whose blood pressure is elevated may lead to increased anxiety and push the anaesthetist towards, or over the top of, their Yerkes–Dodson curve.3

I may not be always so risk averse; but I do feel that anaesthesia for elective procedures should be as risk free as possible. Surely the preemptive correction of minor degrees of hypertension is more appropriate than the use of invasive monitoring and high dependency care in these cases?

In the light of increasing public awareness of the problems of obesity and alcohol abuse, should advice on weight loss and reduction of alcohol consumption (and their effects on blood pressure)4 not only be part of every hypertensive patient’s preoperative assessment; but also be issued to them in surgical outpatient clinics?

J. Palmer
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Editor—We are most grateful for the opportunity to reply to Dr Palmer’s letter. He raises two points. The first is to suggest that the correction of minor degrees of hypertension before surgery is more appropriate than the use of invasive monitoring and high dependency care in these cases. For admission blood pressures between 120/80 mm Hg and 180/110 mm Hg we were unable to find any evidence of increased perioperative risk. We accept that it is biologically plausible that such blood pressures may confer a small increase in risk. However, this effect is beyond the resolving power of currently available studies, and major cardiovascular risk factors such as heart failure and known ischaemic heart disease are more important indicators of perioperative risk. We have tried to produce guidelines that are pragmatic and clinically useful and, on this basis, we felt unable to recommend deferring surgery to control a risk whose existence we cannot demonstrate.

For admission blood pressures persistently above 180/110 mm Hg, the position is less clear. While there are no data to support an increased incidence of adverse events in this group of patients, the work of Prys-Roberts and colleagues does suggest that patients with very high blood pressures display a greater fall in blood pressure at induction of anaesthesia and are more prone to intraoperative myocardial ischaemia.5 It is for patients with blood pressure elevated to this level that we suggest that anaesthesia and surgery should be deferred where possible to allow the blood pressure to be controlled and, where this is not possible, the use of invasive monitoring and high dependency care may be appropriate.

We would emphasize that we seek to offer guidelines to aid the clinician, not edicts to ordain patient care. There will certainly be circumstances in which persistently elevated admission blood pressure may, of itself, be a cause for concern. Refractory hypertension in a young patient, suggestive of secondary hypertension, is one such circumstance.

Dr Palmer’s second point, on the role of the anaesthetist and surgeon in the primary and secondary prevention of cardiovascular disease, is very well taken. Smoking, obesity and alcohol abuse are difficult problems to tackle but, as physicians concerned with the well being of the whole patient, they certainly fall within our remit.

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Remifentanil is too potent to be given by bolus

Editor—We read with interest the study evaluating bolus injection of remifentanil in spontaneously breathing human volunteers by Egan and colleagues.1 Using a randomized, double-blind, placebo-controlled, dose-escalation, crossover study design, a total of 64 healthy subjects received remifentanil or placebo by bolus injection (1–3 s) in a fixed unit dose separated by a 1 h washout period. Groups of six subjects were studied at the initial dose of 25 µg and at subsequent doses of 25 µg increments until a total of four out of the six subjects in any one group had experienced respiratory depression, or the maximum dose of 200 µg had been reached. From their extensive investigation, the authors were able to conclude that bolus injection of remifentanil would be potentially safe and effective in clinical situations, despite the fact that a number of the volunteers in