insertion site, clavicular notch, and carina is a subjective measure which may lead to bias and erroneous results.

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Editor—We would like to thank Dr Farooq for his interest on our article. 1 However, there seems to be some misunderstanding. The practical purpose of our study was not to prove that a CXR may be omitted after central venous catheterization, but to minimize post-procedural adjustments of central venous catheter insertion depth. We agree that our technique is not so helpful for patients without prior CXR. Patients likely to require central venous catheterization may well have a CXR taken before operation or before being admitted to ICU. Although it was not studied, it is probable that optimal central venous catheter insertion depth should depend on the distance from the insertion point to the clavicular notch. Besides, it is possible that very tall patients would have the clavicular notch appear more peripherally on the CXR, augmenting the clavicular notch to carina distance as the parallax effect would be greater peripherally. However, because routine posterior–anterior CXR is taken at a fixed distance between the X-ray tube and film (72 in), we think that such bias is negligible in most cases. If we measure the insertion point to clavicular notch distance after insertion of a guidewire or catheter, there is no reason to introduce any serious error during simple distance measurements.

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Postoperative management of patients with obstructive sleep apnoea syndrome

Editor—Patients with sleep apnoea are particularly at risk from the respiratory depressant effects of inhaled anaesthetics, sedatives, and opioids after operation. Reduced upper airways tone during deeper rapid eye movement (REM) sleep and stage 3 and 4 non-REM sleep may make hypoxic damage more likely. 1 Continuous positive airways pressure (CPAP), a means of preventing airway collapse, is the definitive treatment for sleep apnoea. Some patients have their own machines at home and the American Society of Anesthesiologists recommends that either CPAP or non-invasive positive pressure ventilation should be administered after operation to patients using these modalities before their operation. 2

We have explored the use of protocols to manage these patients. A questionnaire survey was sent to 199 Consultant anaesthetists based in 102 hospitals in the UK. The respondents were asked if their anaesthetic department had a protocol for the management of sleep apnoea patients after operation and related questions about the use and availability of CPAP.

Seventy-two replies were received, giving a response rate of 36%. Only 4% of respondents stated that their hospital had a protocol for the postoperative management of sleep apnoea patients. The absence of such protocols creates the potential for great variety in how these patients are managed and possibly poorer outcomes for some patients. It raises questions about what criteria anaesthetists are using to guide patient management.

The majority (85%) of respondents said that they would ask patients to bring their own CPAP machines to hospital, but 46% advocated the provision of hospital-owned CPAP machines to patients. However, 23% disagreed with this policy. Only 17% of respondents thought that their hospitals would always be able to provide sleep apnoea patients with CPAP machines.

Few UK hospitals appear to have protocols for the management of sleep apnoea patients after operation. There appears to be a lack of consensus in the practices adopted by anaesthetists when managing these patients. We recommend the implementation of evidence-based guidelines at a national level, which should in turn generate the development of protocols locally.

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2 Anon. Practice guidelines for the perioperative management of patients with obstructive sleep apnea—a report by the American Society of Anesthesiologists Task Force on the perioperative management of patients with obstructive sleep apnea. Anesthesiology 2006; 104: 1081–93  
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