Dr. Stanley's concern about a possible GlideScope® letter to the patients, I am more concerned about anesthesiology residents getting less experience with direct laryngoscopy, especially in difficult intubation scenarios because of an increasing GlideScope® use. Direct laryngoscopy is an essential skill, and every effort should be made to maintain and improve it, especially in difficult scenarios, or else, future generations of anesthesiologists may find difficult airways more challenging, should such gadgets not be available for some reason.

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In Reply:

Dr. Sharma makes some very valid observations about the efficacy of the GlideScope® (Verathon Medical, Bothell, WA) and how, with this device, visualization of glottic structures can sometimes be accompanied by a frustrating inability to actually pass an endotracheal tube. Nevertheless, the GlideScope® is just one of a wide variety of video-assisted intubation devices that are now being used with increasing frequency, often as a first-line instrument. My principal concern, which prompted the correspondence,[1] is that neither is there currently a standard for documenting the use of these devices nor is there a consistent means of informing the patient that such a device was used. This could have significant implications for a future anesthetic, particularly if the anesthesia provider does not have access to a video-assisted device.

In the time since my initial correspondence, I have devised a difficult-intubation letter, which takes the form of an Excel spreadsheet template (Microsoft Corporation, Redmond, WA); it has drop-down menu choices for all of the key elements of a patient's airway evaluation and instrumentation. It takes less than a minute to complete, has been adopted by our large group practice, and is currently being translated into a variety of languages. I am happy to share this with anyone who is interested.

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Postoperative Opioids Remain a Serious Patient Safety Threat

To the Editor:

The characterization by Dahan *et al.*[1] of overt opioid-induced respiratory depression (OIRD) requiring intervention in postoperative patients as rare and uncommon is troubling.

"Failure to Rescue" and postoperative respiratory failure (also known as Code Blue) are the first and third most common patient safety-related adverse events affecting the Medicare population in U.S. hospitals, accounting for 113 events per 1,000 at-risk patient admissions, and they result in death or anoxic brain injury in the majority of cases.* The resuscitation literature suggests that the most common antecedent vital sign abnormality to a cardiopulmonary arrest is respiratory in nature, and the worst outcomes often occur on the general care floor (GCF) and in patients whose preexisting morbidity score is low.[2–4] Fifty percent of Code Blue events involve patients receiving opioid analgesia.[5]

Diagnosing narcotic overdoses in hospitalized patients is difficult and often missed; yet, this circumstantial evidence implicating opioids in serious adverse events in the resuscitation literature is not apparent in the anesthesia literature. This may be because the anesthesia literature myopically focuses on surrogate measures of respiratory depression such as respiratory rate and Spo_2. These measures not only provide very "limited information" and are "loose indicators" of ventilatory adequacy, as acknowledged by Dahan *et al.*, but our literature also suffers from a lack of standardization, uses arbitrary threshold criteria, and predominantly comprises retrospective analysis of intermittent and manually charted data.[6] As such, these data are unreliable when compared with

* http://www.healthgrades.com/media/dms/pdf/PatientSafetyInAmericanHospitalsStudy2009.pdf. Accessed January 15, 2010.