In Reply:

I would like to thank Dr. Wlody for his letter expressing concern about the image we created for the November 2015 issue of Anesthesiology. We took the photograph to illustrate the great diversity among individuals who are now entering the field of anesthesiology. My colleagues in the Department of Anesthesiology, Perioperative and Pain Medicine at Brigham and Women's Hospital in Boston, Massachusetts, were kind enough to help me create this image. My instructions to the group were to congregate in the main hospital lobby, *inside the facility*, where the image was taken.

Dr. Wlody is hinting at an important topic that has caught the attention of regulatory bodies in recent years, including The Joint Commission and the Massachusetts Department of Health. There is currently much focus on surgical attire that can be linked to the recommendations published by the Association of periOperative Registered Nurses (AORN).[1] This group has summarized the available scientific evidence regarding the use of various components of surgical attire and put forth a set of recommendations that are widely being held as the current standard by regulatory organizations. Much of the science is weak, yet many of the AORN recommendations appear logical. The newest AORN guidelines are strict: all facial hair must be covered; face masks should be tied tightly in place or completely removed, never worn dangling loosely around the neck; arms should be completely covered with long-sleeved surgical attire; and all attire worn in the operating room must be newly laundered in a healthcare–accredited laundry facility.

For the cover photograph, our group assembled in the lobby, and no one ventured outside of the facility in their operating-room attire. There does not appear to be an increased bacterial contamination when surgical attire is worn inside and outside the perioperative suite within the facility,[2] and the AORN guidelines call for a change to newly laundered attire only when entering the perioperative environment from outside of the facility. Nonetheless, Dr. Wlody's point is well taken. We all should pay close attention to our own personal conduct to minimize avoidable risk to our patients. Strict hand washing and wearing newly laundered surgical attire that has never been worn outside of the facility are two simple ways that are likely to help make the environment we work in safer.

Competing Interests

The author declares no competing interests.

James P. Rathmell, M.D., Brigham and Women's Health Care and Harvard Medical School, Boston, Massachusetts. jrathmell@bwh.harvard.edu

References

1. Association of periOperative Registered Nurses (AORN): Guideline for surgical attires, Guidelines for Perioperative Practice. Denver, AORN, 2015, pp 97–119
2. Sivanandan I, Bowker KE, Bannister GC, Soar J: Reducing the risk of surgical site infection: A case controlled study of contamination of theatre clothing. J Perioper Pract 2011; 21:69–72

(Accepted for publication January 11, 2016.)

Cardiovascular Implantable Electronic Device Service as an Anesthesia Service

To the Editor:

I read with great interest "Initial Experience of an Anesthesiology-based Service for Perioperative Management of Pacemakers and Implantable Cardioverter Defibrilators" by Rooke *et al.*[1] At our medium-sized hospital, the anesthesia group has been providing cardiovascular implantable electronic device service since 2010. All members of the group are expected to perform this service on their patients. We received training and equipment from the manufacturers, but nothing as rigorous as what you describe. With around an hour of training on each device, we were competent to (1) interrogate to evaluate settings, (2) decide upon and initiate an appropriate deactivation of function, (3) initiate appropriate reactivation of function, and (4) confirm whether the settings on discharge were the same as those on initial interrogation. Our preoperative testing department reviews device information with patients before their arrival, and all patients must have an interrogation completed within the last 6 months. On the rare occasion that we find problems with any settings, we contact the company representative and treating cardiologist. All training sessions were videotaped and can be reviewed by the providers as a refresher. While I appreciate the extra work your providers did to obtain a deeper understanding of these devices and their management, I don't know if that is a realistic or necessary goal for most groups. Waiting for the cardiology team or a company representative, who usually just places a magnet and says, "Good to go," isn't a good solution either. This service has been a huge improvement to our previous process and is looked upon favorably by the hospital administration. I would recommend that all practices seek a pathway to offering these abilities by whatever means the administration feel comfortable with.

Competing Interests

The author declares no competing interests.

Joshua R. Berris, D.O., Beaumont Health–Farmington Hills, Farmington Hills, Michigan. berrisj1@msu.edu

Reference

1. Rooke GA, Lombaard SA, Van Norman GA, Dziersk J, Natrajan KM, Larson LW, Poole JE: Initial experience of an anesthesiology-based service for perioperative management