

CORRESPONDENCE

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In Reply:—We disagree with Link's suggestion that physostigmine be administered to a patient who exhibits delirium and agitation while being treated with transdermal fentanyl. Although some data from animal models, as cited by Link, would suggest that opioids may impair central cholinergic transmission, no such data exist for humans. The mechanisms underlying neuroexcitatory phenomena due to opioids are not clear. Central anticholinergic syndrome could be included in the differential diagnosis, but its inclusion would not change the recommended management of the reported case. Although administration of physostigmine may generally be considered benign and without serious side effects, rapid administration may result in hypersalivation, respiratory difficulties, and convulsions. In addition, the duration of action of physostigmine is relatively short, approximately 45–60 min.* After removal of a transdermal fentanyl system, serum fentanyl concentrations decrease slowly, requiring approximately 17 h to decrease by 50%, due to a depot of fentanyl in the skin.† It is unclear how a single administration of physostigmine

would provide lasting benefit in this circumstance. Were the patient's mental status to improve with administration of physostigmine, overnight observation would still be recommended because of the presence of a fentanyl depot and likely recurrence of symptoms, as well as the possible occurrence of opioid withdrawal. Finally, no specific diagnostic tests are recommended unless clinically indicated. It is likely, however, that they will have been performed already, as occurred in this case, before a pain management specialist is consulted.

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* Antilirium package insert, Forest Pharmaceuticals Inc., St. Louis, MO.

† Durageic package insert, Janssen Pharmaceutica, Titusville, NJ.

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Teaching Airway Management Skills: What about Patient Consent?

To the Editor:—Despite initiatives by individuals¹ and by the American Society of Anesthesiologists,² many residency programs have been slow to offer formal training in airway management.³ Koppel and Reed highlight a number of difficulties that "thwart residents' exposure" to such training, such as limited opportunities and inexperience with various devices and techniques.³ New Accreditation Council on Graduate Medical Education guidelines now mandate that these skills be taught.* Such training is very important, given the frequency and severity of adverse events associated with airway management.⁴

Some centers have devised innovative ways to teach airway management,⁵ for example, the University of California San Diego Airway Rotation.⁵ What is not clear is the anesthesia community's opinion

about teaching airway management skills without first obtaining patient consent. Consent is not mentioned by Cooper and Benumof in their description of the University of California San Diego Airway Rotation.⁵ Koppel and Reed do not state in their survey whether residency programs obtain consent from patients who are used for such training.³

The question of consent may seem like a nonissue to some. What is the difference between selecting, for teaching purposes, a Miller or a MacIntosh blade; a laryngoscope or a light wand; a fiberoptic bronchoscope or a retrograde intubation? The difference is in the degree of risk to patients when the procedure may be unnecessary to their care. When one reviews reports of the teaching of airway management skills, some centers do,^{6–9} and some do not, obtain patient consent.^{3,5,10–12}

We believe that, for teaching purposes, simple substitutions of laryngoscope blades or the use of devices such as laryngeal mask airways or lightwands is appropriate without patient consent. The Combitube may be an exception; although the risk of esophageal

* Resident Review Committee for Anesthesiology: Revisions to Program Requirements for Anesthesiology. ACGME, Chicago, June 20, 1995.