Letters to the Editor

Is the education available to anesthetists adequate to provide sedation in endoscopy units?

Key words: Sedation. Anesthetist. Endotracheal intubation.

Dear Editor,

I have carefully read the paper by Luzón Solanas et al. (1) on deep sedation for endoscopic retrograde cholangiopancreatography (ERCP) where they conclude that the use of propofol by trained endoscopy staff is safe during complex endoscopic procedures such as ERCP. However, in routine clinical practice, endoscopy units working with anesthetists have varying approaches to sedation:

- In some hospitals, anesthetists consistently provide endotracheal intubation for ERCP, forgetting about the extra risk of general anesthesia. In many cases, this procedure is often unnecessary. Goudra et al. (2) compare the prone position used for ERCP with the prone position used for neurosurgery and explain that the difference between surgery and ERCP is that endoscopy may be interrupted and spontaneous ventilation is maintained. They also emphasize the risks associated with laryngoscopes and tracheal tubes, in addition to those associated with muscle relaxant drugs, which are not negligible. The prone position is more challenging for airway maintenance and anesthetists use this as an argument to justify intubation. However, ERCP is performed without intubation in an ever increasing number of institutions (3). Moreover, some endoscopy units are already routinely using a left lateral position for ERCP. However, intubation is still necessary for some procedures.

- Another dysfunction seen in other centers is the placement of high-risk patients (ASA IV) in the operating room (OR) in a similar manner to surgical patients, even though sterilization is not mandatory as in open surgery. This may also involve the transfer of materials (catheters, prostheses, X-ray C-arm, etc.) and staff to other areas, which seriously disrupts the standard work cycles. As a consequence, this increases endoscopy procedure costs with OR-like performance times and longer procedure durations. The issue regarding high-risk patients should be clarified by the Sociedad de Anestesia, as anesthetists are responsible for assigning these cases for treatment in the OR.

- On the other hand, endoscopists should advise about which patients do require endotracheal intubation, whether management of the upper cervical esophagus is required; the performance of a lengthy endoscopic procedure, the control of a high risk of bronchial aspiration or to the need to keep the patient immobile. Furthermore, we should bear in mind that sedation should be selected for pediatric patients according to their age and clinical status (4).

These comments aim at encouraging similar behaviors among anesthetists, as not all anesthetists in the same team have the same opinion, in order to provide the optimum benefit and safety of patients. Anyway, a standard diagnostic endoscopy, even for an ASA-IV patient, should not be considered as on a par with a surgical procedure, as this will result in the use of the OR and increased endoscopy costs, and may also result in a cancelation of a scheduled surgery on the waiting list.

Establishing which endoscopies may or may not be performed in the OR is important in order to enhance efficiency. This should be accomplished according to the characteristics of each center (fiber-optic intubation by anesthetist, X-ray system availability, etc.) and endoscopic technique, rather than ASA score alone.

References


Is the education available to anesthetists adequate to provide sedation in endoscopy units?
