Reply from the authors

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J. L. Joris* and G. A. Hans

Liege, Belgium

E-mail: jean.joris@chu.ulg.ac.be

Editor—We thank Dr Drummond for his interest in our article and particularly for his comment on our results on postoperative blood oxygenation. He also reminds us of the significance of functional residual capacity (FRC) and lung function tests, which is welcome and relevant because frequent misinterpretations are found in the literature.

We would, however, like to clarify that we did not state, ‘General anaesthesia causes a reduction in functional residual capacity (FRC) that can last several days’ but rather, ‘General anaesthesia decreases functional residual capacity (FRC) and causes atelectasis. After upper abdominal surgery, FRC remains decreased in the immediate postoperative period and then recovers slowly over several days.’ Our sentences do not assume that the changes induced by general anaesthesia alone persist for several days but refer to the combined effects of anaesthesia and upper abdominal surgery. These effects are well described in the literature. Although most studies in the field were carried out after open abdominal surgery, computed tomography scan after upper abdominal laparoscopic surgery also showed atelectasis 24 h after surgery.

We agree with Dr Drummond that the fact that we did not observe any reduction in FRC 24 h after surgery despite a decreased intraoperative compliance and no recruitment suggests that intra- and postoperative atelectasis are different entities and have a different pathophysiology.

We also would like to take this opportunity to emphasize that our study remains so far the only study to have investigated the independent effect of recruitment manoeuvres in a lung-protective ventilation. Such studies are needed, as stated recently by Futier and colleagues. We did not demonstrate any postoperative benefit of recruitment manoeuvres when combined with lung-protective ventilation during upper abdominal laparoscopic surgery. Two recent multicentre studies reported opposite clinical outcomes of lung-protective ventilation strategies including recruitment manoeuvres after open abdominal surgery. Further studies are needed to determine the exact place or contribution of lung recruitment during intraoperative protective ventilation.

Declaration of interest

J.L.J. has received a travel grant from Abbott and Fresenius-Kabi. G.A.H. has received a travel grant from MSD, Astra-Zeneca, and Fresenius-Kabi.

References

4. Futier E, Marret E, Jaber S. Perioperative positive pressure ventilation: an integrated approach to improve pulmonary care. Anesthesiology 2014; 121: 400–8

Videolaryngoscopes confer benefits in human factors in addition to technical skills

F. E. Kelly*, T. M. Cook, N. Boniface, J. Hughes, C. Seller and T. Simpson

Bath, UK

E-mail: fiona.kelly@doctors.org.uk

Editor—We read with great interest the editorial by Zaouter and colleagues describing videolaryngoscopy (VL) as a new standard of care. We have been using VL regularly in our institution for the past 4 years, and agree that VL represents a significant advance in