Emergent scans are performed by Emergency physicians, are medically indicated, occur in the emergency department, are rapid, goal directed, evidence-based, not difficult and will decrease time to diagnosis. Less training time is required to master emergent scans. The Society of Academic Emergency Medicine recommends only 40 hours of didactic teaching and by 150 clinically-indicated examinations. This could easily be accomplished during a 5-year EM residency and might even be possible within the CCFP(EM) curriculum.

Importantly, the recognition of the emergent scan as distinct from the definitive radiology U/S should facilitate a more open dialogue with our radiology colleagues. Perhaps if radiologists realized that emergent scans are not a threat to their incomes, then a more collegial interaction could occur.

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References

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Esophageal detector devices and children

To the editor:
Rhine and Morrow suggest that the esophageal detector device (EDD) is a useful adjunct for confirming tube placement in adults. It may be less accurate in young children.

The EDD was evaluated in 20 children under 1 year of age undergoing elective surgery. All were intubated and had a second ET tube placed into their esophagus. An observer, blind to tube placement, was then asked to use a modified EDD and aspirate from one of the tubes. Esophageal tube placement was identified correctly in 7 of 10 cases and tracheal tube placement in 8 of 10 cases, giving an overall failure rate of
25%. The authors suggest that failure to recognize esophageal placement could occur if gastroesophageal reflux or hiatus hernia allow gas to be aspirated from the stomach, if the esophageal tube is passed into the stomach, or if the esophagus doesn’t readily collapse and form a seal around the tube. Failure to confirm tracheal tube placement could occur if young childrens’ more flexible tracheal rings fail to hold the airway rigidly open or if the tracheal mucosa collapses over the tube when negative intraluminal pressure is applied.

Relying on the EDD to confirm proper placement of an ET tube in young children may be dangerous.

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References
1. Rhine DJ, Morrow DJ. Is the esophageal detector device or end-tidal CO₂ measurement superior in confirming endotracheal tube placement? CJEM 1999;1(2):103-4.

Propofol for sedation

To the editor:
In the July issue of CJEM, Innes stated that he was unaware of any Canadian emergency physicians who are permitted to use propofol. In fact, we have used propofol for procedural sedation and as an induction agent for intubation since 1995. Among our emergency physicians it has become the agent of choice (in combination with appropriate analgesia), particularly for orthopedic procedures. Although we have not been tracking its use, we are unaware of any adverse outcomes. Due to its rapid onset, short duration, and ease of titration, we find it easier to employ when one physician performs the procedure while another manages the sedation.

We have been performing policy-driven conscious sedation since the mid-1980s. Our procedural sedation policy was written in consultation with our Anesthesia Department and has their approval. Although the policy does not refer to the use of specific agents, our anesthetists have not objected to our use of propofol. In fact, they (and our surgeons) have grown to expect it and depend on it!

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Reference

Correction
In Dr. Del Donald’s Letter to the editor in the July 1999 issue of CJEM, we mistakenly gave Sudbury, Ont., as Dr. Donald’s city of practice. Dr. Donald practises in Sarnia, Ont. We apologize for this error.

Reference

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