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Sir,—We appreciate the letter of Camprubi and Sabate which relates to our recent article on mucosal pH (pHi) during orthotopic liver transplantation (OLT). Their preliminary data suggest that the use of a venovenous bypass (VVB) during the anhepatic stage of OLT may indeed be beneficial for mucosal oxygenation: in contrast with our results, gastric pHi, was preserved with VVB, but decreased transiently without VVB. As pointed out in our article, we were unable to strictly test the hypothesis that VVB would maintain mucosal blood flow as VVB was used routinely at our institution. Therefore, we cannot exclude the possibility that pHi, values might have decreased to even lower values without VVB. The main purpose of our study was to assess the ability of tonometry to detect intrapulmonary mucosal hypoxia, to measure gastric and sigmoid pHi, and to relate the observed changes in pHi, to the occurrence of endotoxemia and primary graft function.

Although in the preliminary report of Camprubi and colleagues, important information on patient physical status and determinants of tissue oxygenation is lacking, the fact that cardiac index, oxygen extraction and lactate concentration are comparable with the values measured in our study suggests that the different results for gastric pHi, during the anhepatic stage may be attributed to the more severe chronic impairment of intestinal perfusion in our patients with end-stage cirrhosis. This is supported by the lower pHi, values measured early during hepatectomy in our study (7.28 ± 0.09). In fact, low pHi, values (>7.32) before the second postoperative day, an observation that further supports the presence of chronic impairment of mucosal microcirculatory perfusion. Hence, pre-existing chronic mucosal hypoxia might explain why pHi, decreased during the anhepatic stage, although overall portal blood flow was maintained by the use of VVB.

It also cannot be excluded that the apparent difference in baseline pHi, values between our study and that of Camprubi and colleagues is a result of the use of different blood-gas analysers. Riddington and colleagues and Takala and colleagues have shown that direct comparison of pHi, values obtained by different analysers is not valid. Therefore, it was recommended that each institution should determine its own reference values for pHi,.

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Volatile anaesthetics and neuromuscular block

Sir,—I read with interest the article by Dr Vanlinhout and co-workers and agree that the magnitude of potentiation in the interaction between sevoflurane and neuromuscular blocking agents. Unfortunately their study merely adds to the confusion. They concluded that sevoflurane and isoflurane potentiated neuromuscular blocking drugs to a similar degree. It is not possible to draw such a conclusion from the data presented in their article.

For vecuronium alone, they found an ED<sub>50</sub> of 16.9 μg kg<sup>-1</sup>. With the degree of variability reported and assuming that a 20% reduction in dose requirements is clinically relevant, their study had, at best, only an 11% chance of demonstrating such a reduction. That is, if the reduction in vecuronium dose reported in the presence of sevoflurane (ED<sub>50</sub> of 14.4 μg kg<sup>-1</sup>, 17% less than with isoflurane) was not a real (rather than chance) occurrence, then 204 patients would have to have received each of the anaesthetics to have an 80% chance of demonstrating such a difference at the 0.05 significance level.

We should interpret their study with caution. The results of their study are entirely in keeping with there being a clinically important difference in the degree of neuromuscular blocker potentiation manifest by sevoflurane and isoflurane.

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in the potentiating abilities of isoflurane and sevoflurane on the effects of neuromuscular blocking agents, that is a significant difference in both depth and duration, sample sizes of several hundreds of patients per neuromuscular blocking group would have been required. Such sample sizes are beyond practicable limits. We selected our population carefully, using rigid inclusion criteria, as described in the text, to reduce patient variability. This inevitably introduced constraints such as the availability of large numbers of eligible patients within a reasonable period of time. Any investigator is limited by both resources and time. Additionally, our study was intended as a phase II trial to evaluate the interaction between sevoflurane and neuromuscular blocking agents within a limited number of surgical patients.

Both the investigator and clinician should be concerned about the ability to detect an important clinical difference. Different investigators disagree on what is a clinically significant difference. They also disagree on the risk they are willing to take of missing a meaningful effect caused by drug interaction. The choice of a 20% difference in ED₅₀ as a clinically significant value is arbitrary. Such a difference is small compared with the large inter-individual differences in the response to neuromuscular blocking agents. With the degree of variability and sample sizes used in our study, a 30% reduction in the ED₅₀ of pancuronium and atracurium and a 45% reduction in the ED₅₀ of vecuronium had an 80% chance of being significant at the 0.05 level.

Finally, we still feel that further interaction studies on the influence of higher concentrations of volatile anaesthetics on larger doses of neuromuscular blocking agents are warranted. To elucidate small but significant differences in the ability of isoflurane and sevoflurane to potentiate the action of neuromuscular blocking agents, these interaction studies need to be performed in volunteers who are studied twice, receiving isoflurane on one occasion and sevoflurane on the other.

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T. DE BOO
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Cusum: a statistical method to evaluate competence in practical procedures

Sir,—It was interesting to read the commentary by Kestin describing the use of cusum analysis to measure the competence of anaesthetic trainees at practical procedures. The cusum is a useful graphical tool for discerning trends from a series of observations. The derivation of boundary lines for sequential tests allows comparison of the observed proportions of success or failure against predetermined standard criteria. This could be developed into a continuous performance monitor in anaesthesia.

In his article, Kestin discussed the problems of keeping paper records and plotting fractions on the graphs. In response to this we set out to develop a computerized personal log book system for practical procedures to run in parallel with the electronic anaesthetic log book on the Psion 3a. However, in setting up the algorithms we have encountered a number of problems.

The values for s, h₀ and h₁ calculated using the formulae in the appendix do not agree with the values in table 1 of the article. On reviewing the original articles on the composition of the cusum, the value of Q should read Q = Ln [(1 − p₀)/(1 − p₁)]. The values in the table are indeed correct if this calculation is used for Q.

The null hypothesis in the article is stated as "the true failure rate is NOT different from the acceptable failure rate" and if the cusum exceeds h₁ then it is rejected. This does not imply that the true failure rate exceeds the unacceptable failure rate which is the performance indicator which interests us. Similarly the alternative hypothesis is stated as "the true failure rate is equal to or exceeds the unacceptable failure rate" and if the cusum decreases to less than h₀ then it is accepted. Surely this would imply that the failing cusum of registrar B in figure 1 has a true failure rate that is equal to or exceeds the unacceptable failure rate.

p₀ corresponds to the failure rate under the null hypothesis which should surely read "the true failure rate is not different from the unacceptable failure rate". If the cusum exceeds h₁ then this hypothesis is accepted and the trainee's performance is unacceptable with reference to the agreed unacceptable failure rate. Similarly p₁ corresponds to the failure rate under the alternative hypothesis which should surely read "the true failure rate is equal to or exceeds the acceptable failure rate". If the cusum decreases to less than h₀ then this hypothesis is rejected and the trainee's performance is no worse than the accepted failure rate.

Furthermore, there appear to be clearcut criteria in the definition of success or failure for a particular procedure. This is confusing and it is difficult to see why type 1 and 2 errors of 10% (0.1) where chosen.

For reasons of convenience for the plotting of the graph, the values of s, h₀ and h₁ where multiplied by 10. It is not clear if, in the event of a success or failure, the graph was started or continued. The statistical method described by Kestin appears to be a very powerful analytical tool and may have a wide range of applications in the assessment of trainees. However, the errors and inconsistencies in the appendix are a source of confusion. It would be useful if the derivation of the definitions, variables, hypotheses and theory behind the calculations were explained more clearly.

E. J. HAMMOND
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Sir,—I would like to thank Drs Hammond and McIndoe for their interest, and in particular for correcting the error in the formula for Q in the appendix—p₀ and p₁ have been transposed.

In answer to their other comments, the advantages of using α and β of equal magnitude is explained in the methods section; the choice of 0.1 was a compromise between the common values for α of 0.05 and β of 0.1 or 0.2 used in clinical studies. The software on the Psion 3a can be used to record and display the cusum; in this case, it is not as helpful to have α and β equal than if graphical methods are used. The graphs used by our trainees were plotted using the nearest integers to 10α and 10 (1−α) as the increments. The original article in the British Medical Journal referred to by Drs Hammond and McIndoe was the article that stimulated my interest in this topic. However, I found it difficult to understand the basic statistical concepts of cusum analysis from this article. I found it even more difficult to write an explanation myself, and I found it even more difficult to write an explanation myself, and I found it difficult to see why type 1 and 2 errors of 10% (0.1) were used.

I. G. KESTIN
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Derriford Hospital
Plymouth

Sir,—We appreciate the letter of Camprubi and Sabate which relates to our recent article on mucosal pH (pHi) during orthotopic liver transplantation (OLT). Their preliminary data suggest the use of a venovenous bypass (VVB) during the anhepatic stage of OLT may indeed be beneficial for mucosal oxygenation: in contrast with our results, gastric pHi was preserved with VVB, but decreased transiently without VVB. As pointed out in our article, we were unable to strictly test the hypothesis that VVB would maintain mucosal blood flow as VVB was used routinely at our institution. Therefore, we cannot exclude the possibility that pHi values might have decreased to even lower values without VVB. The main purpose of our study was to assess the ability of tonometry to detect intraoperative mucosal hypoxia, to measure gastric and sigmoid pHi, and to relate the observed changes in pHi to the occurrence of endotoxaemia and primary graft function.

Although in the preliminary report of Camprubi and colleagues, important information on patient physical status and determinants of tissue oxygenation is lacking, the fact that cardiac index, oxygen extraction and lactate concentration are comparable with the values measured in our study supports the results of their different changes in gastric pH during the anhepatic stage. However, our patients had end-stage cirrhosis, whereas the patients with chronic impairment of mucosal microcirculatory perfusion. Hence, pre-existing chronic mucosal hypoxia might explain why pHi decreased during the anhepatic stage, although overall portal flow was maintained by the use of VVB.

It also cannot be excluded that the apparent difference in base-line pHi values between our study and that of Camprubi and colleagues' patients without VVB had returned to baseline after reperfusion. However, in our patients, gastric pH during hepatic ischaemia, pHi, did not reach normal values (>7.32) before the second postoperative day, an observation that further supports the presence of chronic impairment of mucosal microcirculatory perfusion. Hence, pre-existing chronic mucosal hypoxia might explain why pHi decreased during the anhepatic stage, although overall portal flow was maintained by the use of VVB.

Correspondence

Dr Vanlinhout’s group set out to clarify inconsistencies in the effects of neuromuscular blocking agents and volatile anaesthetics (VVB) during the anhepatic stage of OLT. They preliminary data suggest that different inhalation agents may preclude demonstration of the effects of neuromuscular blocking agents. However, the large between-patient variability in dose-response and dose-duration studies with neuromuscular blocking agents may preclude demonstration of subtle differences in susceptibility to these agents. Therefore, these paired crossover studies can minimize the effect of inter-individual variability. However, these paired crossover studies are difficult to perform with surgical patients. Healthy ASA 1 or 2 patients that are anaesthetized two or more times, receiving on each occasion a different anaesthetic technique, are rare. Therefore, these paired crossover studies have to be performed with volunteers.

Our clinical study was designed as a parallel comparison of different anaesthetic techniques, that is, opioid-nitrous oxide-oxygen, opioid-nitrous oxide-oxygen-isoflurane and opioid-nitrous oxide-oxygen-sevoflurane, in their ability to potentiate the neuromuscular effects of the most commonly used non-depolarizing neuromuscular blocking agents in surgical patients. Using a general analysis of variance (ANOVA) and subsequently the Ryan–Einot–Gabriel–Welsch (REGW) multiple range test to identify eventual sources of difference, there was a significant difference in magnitude and duration of neuromuscular action between the control group, receiving no volatile agent, and the groups receiving inhalation anaesthetics. We were unable to demonstrate any significant difference between the use of opioid-nitrous oxide-oxygen-isoflurane and opioid-nitrous oxide-oxygen-sevoflurane anaesthesia on the effects of neuromuscular blocking agents. In the population investigated, the differences between opioid-nitrous oxide-oxygen-isoflurane and opioid-nitrous oxide-oxygen-sevoflurane anaesthesia were small compared with the between-patient differences in these responses to neuromuscular blocking agents (<10% for the mean values of both magnitude and duration of action). In order to demonstrate significant differences
in the potentiating abilities of isoflurane and sevoflurane on the
effects of neuromuscular blocking agents, that is a significant
difference in both depth and duration, sample sizes of several
hundreds of patients per neuromuscular blocking group would
have been required1. Such sample sizes are beyond practicable
limits. We selected our population carefully, using rigid inclusion
criteria, as described in the text, to reduce patient variability. This
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numbers of eligible patients within a reasonable period of time.
Any investigator is limited by both resources and time.
Additionally, our study was intended as a phase II trial to evaluate
the interaction between sevoflurane and neuromuscular blocking
agents within a limited number of surgical patients.

Both the investigator and clinician should be concerned about
the ability to detect an important clinical difference. Different
investigators disagree on what is a clinically significant difference.
They also disagree on the risk they are willing to take of missing a
meaningful effect caused by drug interaction1. The choice of a
20% difference in ED50 as a clinically significant value is arbitrary.
Such a difference is small compared with the large inter-individual
differences in the response to neuromuscular blocking agents.
With the degree of variability and sample sizes used in our study, a
30% reduction in the ED50 of pancuronium and atracurium and a
45% reduction in the ED50 of vecuronium had an 80% chance of being
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Finally, we still feel that further interaction studies on the influ­
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lar blocking agents, these interaction studies need to be performed
in volunteers who are studied twice, receiving isoflurane on one
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Cusum: a statistical method to evaluate
competence in practical procedures

Sir,—It was interesting to read the commentary by Kestin1
describing the use of cusum analysis to measure the competence
of anaesthetic trainees at practical procedures. The cusum is a useful
graphical tool for discerning trends from a series of observations.
The derivation of boundary lines for sequential tests allows con­
parison of the observed proportions of success or failure against
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In his article, Kestin discussed the problems of keeping paper
records and plotting fractions on the graphs. In response to this we
set out to develop a computerized personal log book system for
practical procedures to run in parallel with the electronic
anaesthetic log book on the Psion 3a. However, in setting up the
algorithms we have encountered a number of problems.

The values for $s$, $h_0$ and $h_1$ calculated using the formulae in
the appendix do not agree with the values in table 1 of the article. On
reviewing the original articles2 on the application of the cusum, the
value of $Q$ should read $Q=\ln \left[\frac{(1-p_0)}{(l-p_1)}\right]$. The values in
the table are indeed correct if this calculation is used for $Q$.

The null hypothesis in the article is stated as “the true failure rate
is NOT different from the acceptable failure rate” and if the cusum
exceeds $h_1$ then it is rejected. This does not imply that the
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hypothesis is stated as “the true failure rate is equal to or exceeds
the unacceptable failure rate” and if the cusum decreases to less
than $h_0$ then it is accepted. Surely this would imply that the failing
cusum of registrars $B$ in figure 1 has a true failure rate that is equal
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$Q_0$ corresponds to the failure rate under the null hypothesis
which should surely read “the true failure rate is not different from
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(0.1) where chosen.

For reasons of convenience for the plotting of the graph, the val­
ues of $s$, $h_0$ and $h_1$ where multiplied by 10. It is not clear if, in the
event of a success or failure, the numbers are rounded to the nearest
integer or if $10^{-1}$ or $10^{-2}$ was plotted.

The statistical method described by Kestin appears to be a very
powerful analytical tool and may have a wide range of applications
in the assessment of trainees. However, the errors and inconsist­
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