Radiofrequency ablation of arrhythmias

Sir,

Radiofrequency ablation is a technique that can deliver a high chance of cure with a low incidence of complication for many cardiac arrhythmias. As Dr Marshall has indicated (Vol 60(5), 1999, p. 320), this technique is currently routinely applicable to re-entrant arrhythmias that involve the atrioventricular node as well as the Wolff–Parkinson–White syndrome and many atrial tachycardias. These arrhythmias often present in younger patients and a definitive and curative procedure is often preferable to long-term drug therapy.

For other arrhythmias this technique is becoming established as an effective alternative to drug therapy. In particular atrial flutter, which is often difficult to control with antiarrhythmic drugs, and ventricular tachycardia in normal hearts are amenable to radiofrequency ablation with a high chance of cure. Atrial fibrillation remains difficult to treat with conventional radiofrequency ablation. However, recent evidence that atrial fibrillation may have a focal initiating mechanism in certain patients and new techniques for creating linear ablation lesions within both the right and left atria suggest that this arrhythmia may soon also be routinely managed by invasive electrophysiology.

Linear ablation techniques are also being evaluated for the treatment of ventricular tachycardia resulting from ischaemic heart disease, although the catastrophic results of treatment failure in these patients imply that defibrillator implantation to protect against breakthrough arrhythmia will remain a mainstay of their management.

It is likely that there will be very few arrhythmias that cannot be managed by the use of radiofrequency ablation. Patients with cardiac arrhythmia should at least be offered the choice between long-term drug therapy, symptoms, or a potentially curative procedure, and should be referred early for electrophysiological assessment.

Peter Stafford
Senior Lecturer/Honorary Consultant Cardiologist
Glenfield Hospital
Leicester LE3 9QP

Reflux and the difficult airway

Sir,

In response to the anaesthetic dilemma on *Reflux and the difficult airway* (Vol 60(2), 1999, p. 148), I would like to point out that it is essential to provide a safe and protected airway for any surgical procedures. The author reported a good mouth opening with a thyromental distance of 7 cm which anticipates relative easiness to intubate and hence protects the airway from the near fatal complication of acid aspiration, especially in a patient with restrictive lung disease and acid reflux. I would suggest that the laryngeal mask cuff can be sensed as a bolus of food, causing a reduction in lower oesophageal sphincter tone and hence more chances of regurgitation and aspiration (Deakin, 1996; Bhavani-Shankar et al, 1997; Fukuhara et al, 1997).

As this patient suffers from acid reflux, with no history of anaesthetic difficulties in the past and relative easiness to intubate as per the author's examination, the patient has higher chances of regurgitating and aspirating with a laryngeal mask than with intubation or even with a face mask.

I would suggest that if the author was anticipating a difficult airway because of his ankylosing spondylitis and limited neck movements, he should have opted for awake fibreoptic intubation with senior help and equipment available to prevent the near lethal complication of acid aspiration.

MY Latoo
Anaesthetist
Addenbrooke's Hospital
Cambridge CB2 2QQ

Bhavani-Shankar K, Hart NS, Mushlin PS (1997) Negative pressure induced airway and pulmonary injury. *Can J Anaesth* **44(1):** 78–81

Deakin CD (1996) *Clinical notes for the FRCA.* Churchill Livingstone, Edinburgh: 35

Fukuhara H, Kitamura T, Nishimura Y et al (1997) Aspiration pneumonia during the endotracheal intubation on the occasion of bladder perforation during transurethral resection of prostrate. *Masui* **46(3):** 384–7

Sir,

Dr Latoo makes several assertions which merit discussion.

Tracheal intubation is of course desirable to protect the airway of an anaesthetised patient in the presence of an increased risk of regurgitation. With regard to predicted ease of intubation. the patient had a fixed cervical flexion deformity and a full set of teeth. In addition he had not had an anaesthetic for over 30 years (although unfortunately this was not explicitly stated). Therefore I disagree that one should anticipate easy intubation regardless of the degree of mouth opening or thyromental distance. Failed intubation would have exposed the patient to much greater danger.

Awake fibreoptic intubation would have been a reasonable alternative. Ideally the necessary skilled personnel and equipment should always be available but in reality this is not always so and perhaps the case should have been postponed until they were. Against this was the fact that symptoms were moderately well controlled by omeprazole and so one might assume that appropriate premedication would be effective in reducing residual gastric volume and acidity.

I also concur that the laryngeal mask does not protect against aspiration and may possibly contribute to a reduction of lower oesophageal sphincter tone when compared to a face mask. However, holding a face mask for an hour or more can entail frequent airway manipulations and less 'smooth' maintenance of anaesthesia, perhaps increasing the risk of regurgitation With either technique one must ensure a smooth induction and avoid coughing, bucking, airway obstruction and, if possible, positive pressure ventilation.

I share Dr Latoo's concern for patient safety, but as always, it is a matter of balancing the risks.

Sheridan Rees
Specialist Registrar
Department of Anaesthesia
Gloucestershire Royal Hospital
Gloucester GL1 3NN

Should all images be reported?

Sir,

Gerald de Lacey's editorial (Vol 60(8), 1999, p. 546) summarizes eloquently the difficulties facing radiology departments within the UK, particularly the majority who have no junior trainees to share the daily demands upon already lean systems.

Clinical governance now places quality of service and clinical excellence at the top of the list of priorities for trusts. It might be assumed that specialists with skills in a particular area of medicine might be best used exercising those skills but how much of our reporting is clinically relevant?

Walker et al (1994) found that a staggering 75% of preoperative chest X-rays requested were neither viewed nor were the reports read before the operation. In our own unit 5 years ago we asked our consultant colleagues if they wanted their plain films formally reported. Replies indicated that although the majority found our reports of essential value a minority were happy to take on the reporting role themselves. However, a small number of colleagues felt that we should continue to produce reports even though they were unlikely to read them.

The gatekeeper role of radiologists has served the NHS and public well, illustrated by the low rate of referral as compared to other nations. The POPUMET regulations referred to in the editorial are currently undergoing review (Department of Health, 1999) following a Euratom directive and are likely to require the referring clinician to provide 'sufficient relevant clinical information on the patient to enable the justification of the medical exposure' and that such a requirement of justification will be a duty. The employer will look to the radiologist to ensure that such duties are adhered to in governance terms — it's a vicious circle.

Ray Godwin
Head of Diagnostic Radiology
West Suffolk Hospital
Bury St Edmunds
Suffolk IP33 2QZ

Department of Health (1999) *Proposals for the Ionising Radiation (Medical Exposure) Regulations 1999. Replacing the Ionising Radiation (Protection of Persons Undergoing Medical Examination or Treatment) Regulations 1988.* The Stationery Office, London

Walker D, Williams P, Tawn J (1994) Audit of requests for preoperative chest radiography. *Br Med J* **309:** 772–3