

dence and common sense rather than by the Bar Association, the National Rifle Association, commercial interests and big industry. In addition, *CJEM* is showing us that medical journals don't have to be dry, with a stiff upper lip. An informal approach that is intellectual and, at the same time, humorous, provides the ideal format for learning. Congratulations on a job well done.

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## ED ultrasound

*To the editor:*

I wish to address comments made by Drs. Ducharme and McPhee in the July issue of *CJEM*.<sup>1,2</sup> Their comments on the use of ED ultrasound (ED U/S) seem to reflect common misconceptions about this important diagnostic tool. These doctors suggest that the amount of training required to perform ED U/S is prohibitive and that, to meet the requirements of the Canadian Association of Radiologists, a great deal of EM residency time would have to be reallocated. This might be true if the purpose of such exams was to delineate specific pathologies or disease processes. But ED U/S exams were never intended to be definitive evaluations, which are far too time intensive to be practical in the busy ED setting. On the contrary, ED U/S is meant to provide rapid answers to specific questions, such as: Is there free fluid in the abdomen of this trauma patient? Is there an intrauterine pregnancy in this woman with suspected ectopic? and Does this hypotensive patient have an abdominal aortic aneurysm?

To avoid confusing ED U/S with the comprehensive exams carried out in the radiology suite, I propose that we refer to the former as EMERGENT scans.<sup>3</sup> 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.<sup>4</sup> 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

1. Ducharme J. Ultrasound in the emergency department [controversy]. *CJEM* 1999;1(2):119-20.
2. McPhee D. A radiologist's perspective [controversy]. *CJEM* 1999;1(2):123-4.
3. Sankoff J. Resident education: making a case for training residents to perform and interpret bedside sonographic examinations. *Ann Emerg Med* 1999;34:105-8.
4. Lanoix R. Credentialing issues in emergency ultrasonography. *Emerg Med Clin North Am* 1997;15:913-20.

## EM training

*To the editor:*

I am pleased that Dr. Steiner, in the July issue of *CJEM*,<sup>1</sup> responded to our arti-

cle.<sup>2</sup> He made several interesting points, but I am less than convinced by his arguments. Steiner refers to two clauses in the CCFP Residency Program Accreditation and Certification book that were, in his opinion, taken out of context. This has not been the view of others (from whom Dr. Moore and I have received positive feedback), so I guess interpretation remains a judgement call. In any case, it's clear that the coin does have two sides and that, for now, we'll agree to disagree.

The important issue is to ensure the continuing positive evolution of Canadian emergency medicine. As long as this remains our primary goal, then let the debate continue.

**Cindy-Ann Lucky, MD**  
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### References

1. Steiner I. Emergency medicine training in Canada: a different perspective [letter]. *CJEM* 1999;1(2):91.
2. Moore K, Lucky C-A. Emergency medicine training in Canada. *CJEM* 1999;1(1): 51-3.

## Esophageal detector devices and children

*To the editor:*

Rhine and Morrow<sup>1</sup> 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.<sup>2</sup> 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 children's 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 CO<sub>2</sub> measurement superior in confirming endotracheal tube placement? *CJEM* 1999;1(2):103-4.
2. Haynes SR, Morton NS. Use of the oesophageal detector device in children

under one year of age. *Anaesthesia* 1990; 45:1067-9.

**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.<sup>1</sup> 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!

**Steve Socransky, MD**

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**Reference**

1. Innes G. Emergency department sedation guidelines: a tale of two specialties [editorial]. *CJEM* 1999;1(2):88,136-9.

**Correction**

In Dr. Del Donald's Letter to the editor<sup>1</sup> 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**

1. Donald D. Emergency department sedation [letter]. *CJEM* 1999;1(2):92.

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