unlikely to have occurred by chance. We note this simply as an observation; diagnoses recorded on death certificates were never part of our original hypothesis and cannot be used in the inferential process. We do not agree with Gross et al. that it is scientifically valid to include a long-term outcome (death with a cancer-related diagnosis) in a predictive model based on the perioperative physical status of the patient.

Dr. Roth’s suggestion that blood transfusion and extracorporeal circulation may have synergistic adverse effects is not unreasonable. Certainly, this is one explanation for the observation that cardiac surgery is the only clinical setting where adverse transfusion-related immunomodulation effects have been conclusively demonstrated. Our study data does not help to clarify this suggestion, however, as most of our transfused patients were exposed to extracorporeal circulation.

None of this is any reason to promote the use of blood. The short-term risks are compelling, as are the huge costs and the ever diminishing resource. However, we should not be misinforming patients who have survived more than 2 months after coronary artery grafts that they have a serious risk of premature death as a result of a moderate transfusion of blood products.


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Exposure Limits to Magnetic Resonance Imaging Fields: Invisible Land Mines or Fields to Mine

To the Editor:

We read with interest the article by Roh et al. concerning exposure to low-frequency electromagnetic fields (EMFs) and wish to comment on another great source of exposure to EMF that anesthesiologists face in the hospital. Although the risk factors of magnetic fields are well known for patients, exposure limits to EMFs are unknown in healthcare providers who are continuously exposed to the magnetic resonance imaging (MRI) environment. The MRI environment exposes anesthesiologists to static and gradient magnetic fields, with the exposure limits dependant not only on the strength of the MRI scanner (1.5 T vs. 3.0 T) and length of the scanning sequences but also on which anesthetic technique is chosen and whether the intravenous pumps, monitors, and anesthesia machines used are MRI compatible.

The lack of MRI safe or compatible monitors and machines forces the anesthesiologist to choose a technique that requires being in the magnet room closer to the magnet bore, and thus potential exposure to higher levels of EMF. Not only the exposure is potentially greater but also the tracking of individual anesthesiologist’s exposure time during monitoring is lacking.

Because of the lack of studies of healthcare personnel to the long-term risks of EMF, certain groups are beginning to examine issues such as risk of mortality or cancer rates in personnel working in the MRI environment. Numerous groups, including the World Health Organization, National Health Service (United Kingdom), and the Health Protection Agency, are becoming involved in the design and epidemiologic studies about long-term exposure to EMF in healthcare personnel working in MRI are implemented. The European Union is also proposing a directive that will limit the exposure of healthcare workers to the EMF of MRI magnet rooms. Implementation of these directives will ban anes-

Timothy J. Brennan, Ph.D., M.D., served as Handling Editor for this exchange.

thesiologists from staying in the magnet room during MRI scans. We have not found any studies of MRI-induced injury to healthcare personnel from long-term exposure to EMFs or any studies correlating exposure levels to disease. Anesthesia personnel who provide limited or occasional care in the MRI environment run a risk of exposure to EMFs.3,4 Anesthesia providers should carefully consider their anesthetic technique to minimize the time spent in the MRI magnet room. In the future, exposure limits to EMFs should be recorded by anesthesia personnel to facilitate future epidemiologic studies to determine EMF exposure rates. More research is required in developing anesthetic techniques to minimize the EMF exposure limits.

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In Reply:

We appreciate the comments from Bryan et al. regarding our article that is related to electromagnetic fields (EMFs) in operating rooms, but magnetic resonance imaging (MRI) magnetic rooms. The anesthesiologists have been exposed to a large amount of EMFs in MRI magnetic rooms because of the recent lack of EMF-safe monitors and machines in an MRI environment. However, there is no specific study about the amount of EMFs in MRI magnetic rooms related to the anesthesiologist and long-term effects of EMFs to the anesthesiologist in an MRI environment. We agree with your opinion that anesthesiologists should consider minimizing the time spent in the MRI magnetic room and should start an epidemiological study for the anesthesiologists working in an MRI environment.

European directive 2004/40/EC on occupational exposure to EMFs was to be implemented in the Member States of the European Union by 2008. Because of some unexpected problems, the deadline was postponed until 2012. Now is the time, we think, for all anesthesiologists to be interested in their working environment, especially EMFs in operating rooms, MRI magnetic rooms, and intensive care units.

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Implicit Memory Phenomena under Anesthesia Are Not Spurious

To the Editor:

I read with great interest the article by Hadzidiakos et al. in the August issue of Anesthesiology. These investigators conducted a study of memory function under anesthesia using the process dissociation procedure (PDP), a method that my colleagues and I have used in the same context in the past. In contrast to our studies, Hadzidiakos et al. report no evidence of memory function in terms of word stem completion test performance, a discrepancy for which the authors provide plausible explanations such as the depth of anesthesia and midazolam premedication. However, notwithstanding their null finding, one of the PDP models—the original—produced parameters suggesting the presence of controlled (explicit) and automatic (implicit) memory processes. By extending the model to include guessing parameters, the authors go on to show that the original model produces faulty estimates and that other published results using the original model are faulty. That is, Hadzidiakos et al. find no evidence of any memory processes in three of the four inspected studies when the extended measurement model is applied. They conclude that in these studies there was no contribution (i.e., evidence) of memory at all and that past findings are spurious.

I take issue with this conclusion for several reasons. Foremost, a model that generates discrepant parameters depending on its assumptions or underlying structure should not invalidate the behavioral findings it attempts to model. When significant differences are found in patients’ postoperative behavioral responses to old material presented under anesthesia versus new material not presented before, this difference is real and evidences memory for old material regardless of how the underlying process is labeled. Dismissing these behavioral observations ignores an overwhelming body of evidence in favor of implicit memory (“priming”) phenomena in the cognitive psychology and neurology literature and surely cannot have been the intent of Hadzidiakos et al.