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Letters to the Editor

To the Editor:

The recent article by Drs Douglas and Ritter (''Implementation of an Anesthesia Information Management System [AIMS],'' *The Ochsner Journal*, Volume 11, Number 2) accurately chronicles the AIMS implementation project in our department over the past 2 years. The terrifying idea of converting to an entirely electronic record was very capably shepherded to full acceptance by Dr Douglas and has been a dramatic step forward in the electronic revolution of anesthesiology at Ochsner. As Dr Douglas mentions in his article, implementation has been a multidisciplinary effort. On a personal note, I would also like to thank Shannon deBlanc, CRNA, for her considerable efforts as the go-to person on this project when Dr Douglas was unavailable. She did a tremendous amount of work getting everyone up to speed in the operating room initially and has taken on the ongoing task of helping to close out records day to day.

The real excitement and challenge now lie in what we can do with the database effortlessly generated by our ongoing clinical care. In his Rovenstine Memorial Lecture at the American Society of Anesthesiologists' annual meeting last October, Kevin Tremper, MD, touted the benefits of database research to the specialty in an era of declining reimbursements and continued time pressure on academic clinicians. Dr Tremper succinctly described how, after obtaining institutional review board approval for a project, ''We then did nothing for a year.'' Instead of days spent in cumbersome chart reviews or gathering results on a parallel research record by hand, the data for scholarly projects (some yet to be conceived) are automatically gathered by ongoing clinical care. What remain for the academic anesthesiologist at this point are the ''fun'' parts of research: analyzing the data and writing it up into a publication-worthy context. We've had some early successes. This past year our cardiothoracic anesthesiology fellow, Chris Couch, MD, completed the department's first ''all AIMS'' study, which has been accepted for publication in a national specialty journal. Many thanks to Dr Douglas and his team for their hard work on this important project!

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To the Editor:

I enjoyed Dr Luczak's article on localized myxedema (''Localized Myxedema of the Foot Associated With Trauma and Surgery,'' *The Ochsner Journal*, Volume 11, Number 2). This is a nice review and well documented. We routinely use fine needle biopsy in the clinic but know that there are limitations to fine needle biopsy. In fact, for many instances we prefer an excisional biopsy. In retrospect, this could have changed treatment and outcome. Have the authors changed their protocols for the use of fine needle biopsy and its application?

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Authors' Reply

I would like to thank Dr Richardson for his compliments and acknowledge his valid comments. We do recognize the limitations of fine needle biopsy and acknowledge the importance of histological tissue assessment. Accordingly, our normal practice involves appropriate biopsy mode to obtain definitive tissue diagnosis. Pathologist input is sought in all complex cases.

In our case, local recurrence of originally suspected myxoma—diagnosed on initial excisional biopsy—was investigated with fine needle biopsy and magnetic resonance imaging (MRI). The findings on both investigative modalities were discussed at a multidisciplinary level with a pathologist, radiologist, and plastic surgeons. Given that a neoplastic process was strongly suspected based on aggressive cytology findings, in combination with marked fibrotic tissue proliferation on MRI, surgical clearance was performed rather than further tissue being obtained in the form of an incisional biopsy. Additionally, given the recurrent myxedema's large size, excisional biopsy was not seen as significantly less invasive than complete excision.

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To the Editor:

I want to thank authors Luczak et al for bringing attention to the severity of crush injuries. ''Closed Digital Artery Injuries'' (*The Ochsner Journal*, Volume 11, Number 2) reminds us to consider these traumas as a

diagnostic challenge. The potential of being overlooked could lead to devastating outcomes. It is suggested that unilateral vessel damage occurs with a much higher frequency than is documented. Acute awareness to the mechanism will increase the recognition of this injury.

Of the 9 cases where surgical repair was performed, 6 were labeled as just survival. It is of interest if the fracture type and level of reduction played a role in the functional outcomes of these patients.

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To the Editor:

I would like to congratulate the members of this study group (''Evaluating Safety of Handoffs Between Anesthesia Care Providers,'' *The Ochsner Journal*, Volume 11, Number 2) for evaluating a critical issue in the safety of the practice of anesthesiology. As mentioned in the article, the established method of anesthesia coverage necessitates the handing off of patient care on a routine basis. Although similar to other specialties in that respect, anesthesia caregivers face this process much more frequently because of the nature of the practice. This process works well for the majority of cases, as reported in this article, but there is a significant occurrence of inadequate transfer of information. This has resulted in an occasional serious adverse outcome. The incidence and severity of adverse outcomes might well be an extension of this study requiring a much larger sample size. It has been my experience that poor handoff is not only the result of lack of standardization but is also related to the individual providers who are handing off the information. An extensional study might include anonymous providers, by number identification only, to document this aspect of handoff safety. In the past, a study demonstrated that the incidence of perioperative ischemia varied with the anesthesiologist provider. I am sure that handoff safety does as well. While improving handoff safety with standardization in the practice of anesthesiology, we must remind ourselves of the extremely high safety record of our specialty. The reason our practice has improved in safety over the recent years is the continued efforts for more precautions such as this article exemplifies.

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