Reply

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Thank you for the opportunity to offer additional comment regarding the recently published recommendations of the Task Force on Children’s Surgical Care,1 and the related letter from our colleagues, Drs Fitch and Singleton, on behalf of the American Society of Anesthesiologists. To preempt our conclusion, the Task Force is committed to continued partnership with the anesthesia community, including the American Society of Anesthesiologists, to work together to offer the highest quality of care possible to infants and children who require surgical services.

Drs Fitch and Singleton have raised concerns about ensuring reasonable patient access to appropriate care. This concern has been central to the Task Force discussions from the start. We wish to emphasize that the children’s resources identified by the Task Force are recommendations, not requirements. The verification process proposed does not mandate transfer of patients nor prohibit any specific practitioner activity. Rather, like the American College of Surgeons trauma program, which has published optimal resource standards and performed verification for decades, and is demonstrably successful,2 this is an effort to prospectively define resource standards for children’s surgery based on the best data available and multidisciplinary expert opinion. The intent is to allow institutions, practitioners, and communities to assess locally available resources in the context of contemporary national standards to decide what is best for children in that community. One possibility of course is that new resources will be developed locally. Another is that a family will travel elsewhere. The intent of the Task Force is to allow prospective identification of optimal resources for an individual infant’s or child’s surgical needs. Practitioner, family, and patient decisions will presumably balance travel burden with all of the other relevant issues involved in the child’s care.

More than 5 million infants and children undergo surgical procedures annually in the United States. Given the volume of these services, rare and uncommon events related to anesthesia, even in otherwise healthy infants and children, are certain to occur at a population level, if not at the level of an individual provider or practice. We believe the resources delineated in these Task Force recommendations offer the best opportunity for rescue when these rare and potentially life-threatening events occur. Published literature has demonstrated for decades that young patients have increased anesthesia-related risks when compared with adults,3 and this risk is significantly lessened with pediatric specialty training.4 The unique skills of pediatric anesthesiologists are recognized by the American Board of Anesthesiology, now in the form of a Certificate of Added Qualification in Pediatric Anesthesiology, and also by the Accreditation Council for Graduate Medical Education (ACGME) in the form of differentiated pediatric anesthesia specialty training programs. These Task Force recommendations represent a best effort by a multidisciplinary group of experts to balance patient safety and optimal resources with the pragmatic need for patient access. We believe that the public expects our professional communities to identify and recommend appropriate resources like this—to define the care we would seek for our own families and friends should it be necessary.

Improving clinical practice is a process. We are pleased to embark on this journey with our anesthesia colleagues. We are indebted to Drs Fitch and Singleton and the American Society of Anesthesiologists for their commitment to work together with the Task Force to help delineate optimal resource standards for all infants and children who require surgical care.

REFERENCES

Disclosure Information: Nothing to disclose.

Pedicled Cross-Leg Flaps

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I appreciate the opportunity to respond to the reply letter from Drs Lu, Zhu, Liu, and Jiang1 published in the
March issue of the Journal. They report “satisfactory outcomes” and reference a postoperative video supporting this statement. Without rigorously measuring various parameters, the definition of satisfactory is somewhat subjective and nonblinded.

With respect to the advantages of free flaps in regard to blood flow, the main difference is the need for pedicle flaps to ultimately obtain blood circulation from the wound bed, which necessitates scar formation and adhesions. These are not necessary to sustain free tissue transfers.

I indeed do not accept that cross-leg flaps are “simpler” than free flaps. They often necessitate prolonged complex operations and long postoperative immobilization and positioning.

For surgeons comfortable with and experienced in free tissue transfers, these operations are not prolonged or complex and require very little expensive equipment. As such, they are often “simpler” solutions to these challenging problems.2,3

REFERENCES

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The President’s Been Shot

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I write to congratulate Dr Ronald C Jones1 on his first person account of the emergency room care of President Kennedy more than a half century ago. There are several aspects of the case that I think deserve comment and elaboration.

Dr Jones recalled that Dr Carrico remembered that the President possibly suffered from Addison’s disease and if so, what the etiology was. I had the opportunity to review some of President Kennedy’s medical records at the JFK library in Boston.2 Kennedy more than a half century ago. There are several aspects of the case that I think deserve comment and elaboration.

An article published by an orthopaedic surgeon, Dr James Nicholas, in the Archives of Surgery “reported on the management of perioperative adrenal insufficiency.”4 Only years later did he identify case #3 as Senator John F Kennedy.

As Kennedy’s political career progressed, innuendo continued about his health and his adrenal condition. Just before the 1960 Democratic convention in Los Angeles, several of LBJ’s supporters, including California Governor Edward G “Pat” Brown, again raised the rumor of JFK’s adrenal disease.

Recently, another physician, Lee R Mandel,5 reviewed additional health records of President Kennedy. He noted that in addition to evidence of Addison’s disease, which was likely autoimmune in etiology, Kennedy was treated for hypothyroidism. This led him to the possible hypothesis that Kennedy had autoimmune syndrome type 2 or the Schmidt syndrome. Ultimately, Kennedy’s Addison’s disease was unequivocally confirmed by the presence of scant adrenal tissue at the time of his autopsy.6

Dr Jones also recounted his observation that as he pulled down the President’s trousers to check for a palpable pulse, he noted a back brace held in place by an elastic bandage. The back brace, which was worn by the President because of his chronic spinal problems, has been implicated by some as contributing to his death. Robert Dullek,7 a historian and one of Kennedy’s biographers, theorized that although Oswald’s first bullet struck JFK in the back and exited through the trachea and neck, it was the back brace that held the President erect, rather than slumped over, and permitted the second fatal bullet to penetrate his posterior right skull. Dr Jones’ meticulous recollection of the events of November 22, 1963 is an invaluable contribution to medical history.

REFERENCES
1. Jones RC. The President’s been shot and they are bringing him to the emergency room. J Am Coll Surg 2014;218:856—868.