

# Tips from the Top

## We Should Always Listen to the Patient

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I submit these comments in the hope of restoring a measure of vigilance, which I believe to be the cornerstone of good care, in our specialty.

I have observed that newly-trained anesthesiologists routinely forego the use of precordial and esophageal stethoscopes. I believe that they have been trained to rely upon other monitoring devices currently in vogue. While I applaud the ongoing development of sophisticated monitoring devices, I have great difficulty understanding how an anesthesiologist can have a secure feeling without the direct patient contact afforded by a monaural stethoscope. I have been in private practice for 19 years and continue to find that the precordial or esophageal stethoscope is an essential item in any anesthetic case. These simple, inexpensive monitors provide continuous contact with the patient, produce very practical feedback, and sometimes can avert an adverse event.

Some of the situations in which these devices provide critical information are:

- Immediate detection of partial or complete airway obstruction
- Assessment of proper placement and seating of laryngeal mask airways
- Migration of endotracheal tube into the right mainstem bronchus, especially in pediatric cases with placement of the precordial stethoscope on the left chest
- Wheezing
- Airway secretions with need for suctioning
- Disconnection
- Light anesthesia with swallowing and borborygmi
- Backup in case of airway disconnect or other monitor failure

The precordial and esophageal stethoscopes also offer the advantage of providing the anesthesiologist with an auditory sensory input that can complement the visual formats of the other monitors. This continuous sensory input can be quite helpful in an environment prone to distractions. Consider that even

## Tips from the Top (cont'd)

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when one looks away from a monitor to view the surgical field or to speak with operating room personnel, this powerful auditory input will not be interrupted.

Some recently-trained anesthesiologists seem to feel that they can obtain all the data that they need from other monitors, but I question this practice. How much more rapidly does one hear a wheeze as opposed to noticing a change in the end-tidal carbon dioxide curve? Isn't it much more immediate to hear secretions clogging the endotracheal tube than to notice an increase in airway inflation pressure?

My understanding is that auscultation appears to have been demoted to a position of lesser importance early in medical training. This in turn may have resulted in young physicians who are not comfortable using this modality when making clinical decisions. Whatever the immediate cause, this movement away from auscultation may possibly be dangerous. I am convinced that many adverse events could be averted if a precordial or esophageal stethoscope were deployed. Case reports and case reviews support this assertion. (See [http://www.apsf.org/resource\\_center/newsletter/2004/winter/03turn\\_on.htm](http://www.apsf.org/resource_center/newsletter/2004/winter/03turn_on.htm), an article in the APSF newsletter by Ann Lofsky, M.D.)

In conclusion, I would strongly recommend that we reestablish the use of the precordial or esophageal stethoscope as standard practice in anesthesia care. For those who have not used them, I would recommend starting. You will master these devices quickly and easily, and they will improve your level of connectedness to your patient immediately.