LETTER TO THE EDITOR

Survey of chest physicians regarding patient positioning and operator handedness during fibreoptic bronchoscopy

Fibreoptic bronchoscopy is the primary procedure used by chest physicians for accessing the bronchial tree for diagnostic as well as therapeutic procedures. There have been national surveys of fibreoptic bronchoscopy in UK, which focused on patient preparation, monitoring during the procedure, drug therapy, tissue sampling methods and complications. The current survey’s primary objective was to understand the practices followed, with regards to patient positioning and operator handedness. Questionnaires were sent to 110 chest consultants all over UK, with 93 responses, of which 90 were selected and analysed.

The majority of physicians were right handed (97%). Those with experience between 10 and 20 years (51%) were the majority. The most favoured route of approach was supine or semirecumbent with operator facing patient (56%). Nasal route (64%) was the most widely used.

The majority (57%) of right handed physicians use their right hand for holding the scope. The trainers’ advices were far from similar and hence the interpretation was difficult. This survey may have its implications in training respiratory physicians in the future and a formal training manual will have to incorporate the common or ‘acceptable’ practices as observed in this study.

Fibreoptic bronchoscopy was introduced by Ikeda in 1964 and ever since, this has been the primary modality used by chest physicians for accessing the bronchial tree for diagnostic procedures as well as therapeutic interventions. There appears to be no hard and fast rule regarding patient positioning or operator handedness and physicians adopt practices suiting their handedness as well as various factors like patient comfort and presence of any anatomical variations, which may affect the route of intubation. There have already been national surveys of fibreoptic bronchoscopy in UK, but the earlier ones focused on patient preparation, monitoring during the procedure, drug therapy, tissue sampling methods and complications. The current survey’s primary objective was to understand the practices followed, with regards to patient positioning and operator handedness. Questionnaires were sent to 110 chest physicians all over UK. It asked for the physicians’ normal handedness, number of years of experience in bronchoscopy, patient positioning, route of approach, hand used for holding the scope and for the associated procedures and finally the trainer’s advice regarding which hand to use. There were 93 responses, of which 90 were selected and analysed.

The majority of physicians were right handed (97%). Those with experience between 10 and 20 years (51%) were the majority, followed by those with more than 20 years (38%) and those with experience between 5 and 10 years (10%). The most favoured route of approach was supine or semirecumbent with operator facing patient (56%), followed by supine or semirecumbent with operator behind patient (34%) and 10% had no preference or used any of the positions. Interestingly, among the most experienced group, the percentage adopting either position was similar, with 18 out of 34 facing the patient and the remaining 16 standing behind the patient. Nasal route (64%) was the most widely used, followed by either nasal or oral (27%) and oral route (9%).

Among the 87 right handed physicians, the majority (57%) hold the scope in their right hand, followed by the left hand (37%) and the remainder have no preference. 47% of the right handed physicians use their left hand for doing the procedures, followed by 46% using their right hand and 7% using either hand. All the three left handed physicians use their right hand to hold the scope and the left hand to do the procedures. The trainers’ advices were far from similar and hence the interpretation was difficult. This interesting survey shows that there is wide variation in the techniques adopted by chest physicians for fibreoptic bronchoscopy. Supine or semirecumbent with operator facing patient and nasal route are the most common position and route respectively, but supine or semirecumbent position with operator behind patient may be getting more popular with endobronchial ultrasound being introduced in various centres. This survey may have its implications in training respiratory physicians in the future and a formal training manual will have to incorporate the common or ‘acceptable’ practices as observed in this survey.

Conflict of interest statement

Dr Timothy Howes has received funding from Novartis Pharmaceuticals and Glaxo Wellcome for lecturing and for attending international meetings within the last year.

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References
