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Superior vena caval collapsibility as a gauge of volume status in ventilated septic patients

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Sir: We thank Dr. Miranda for his great interest in our paper recently published in the journal [1]. We are very happy to know that another team is interested in studying the superior vena cava (SVC) by echocardiography, which provides valuable information for assessment of fluid responsiveness. We have acquired great experience in this subject over several years and totally agree with Dr. Miranda that SVC may be studied by a long-axis view rather than a short-axis view. However, unlike Dr. Miranda we have never observed a left-right shift of the SVC during tidal ventilation on a short-axis view. On the other hand, when present, a partial or complete collapse of the SVC is sometimes only observed in a given narrow portion of the vessel and is thus missed when using a short-axis view of the vessel in one specific place. This is particularly well illustrated in Fig. 1. In practice, we always first use a short-axis view to position the probe optimally to obtain the best view of the SVC and then we lengthen the vessel to visualize it over a few centimeters.

EXPI

INSPI

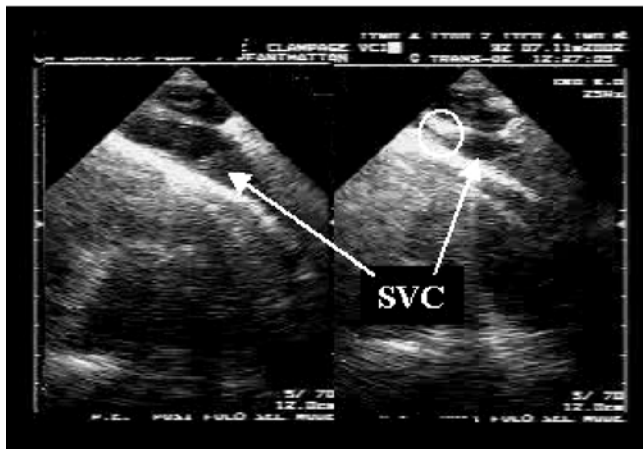


Fig. 1 Superior vena cava (SVC) in a long-axis view at transesophageal echocardiography. Note that tidal ventilation induced a partial collapse in just a narrow portion of the vessel (*circle*). *EXPI* expiration, *INSPI* insufflation

Reference

1. Vieillard-Baron A, Chergui K, Peyrouset O, Page B, Beauchet A, Jardin F (2004) Superior vena caval collapsibility as a gauge of volume status in ventilated septic patients. *Intensive Care Med* 30:1734-1739

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