For these reasons, we believe that fluid expansion must be interpreted with regard to the evolution of SV and HR. It might also be useful to standardize the definition of fluid responsiveness to allow comparisons between studies that use preload indices.

**Declaration of interest**

None declared.

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1 Guinot PG, Urbina B, de Broca B, Bernard E, Dupont H, Lorne E. Predictability of the respiratory variation of stroke volume varies according to the definition of fluid responsiveness. Br J Anaesth 2014; 112: 580–1


3 Starling EH, Visscher MB. The regulation of the energy output of the heart. J Physiol 1927; 62: 243–61

4 Patterson SW, Starling EH. On the mechanical factors which determine the output of the ventricles. J Physiol 1914; 48: 375–9


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**Dynamic optimization of height relation between anaesthetist’s chest and patient’s face during tracheal intubation**

Editor—In a randomized controlled clinical trial assessing the influence of different operating table heights on the quality of laryngeal view and the discomfort of the anaesthetist during tracheal intubation, Lee and colleagues show that higher operating tables provide better laryngeal views for tracheal intubation. Br J Anaesth 2014; 112: 749–55


Walker JD. Posture used by anaesthetists during laryngoscopy. Br J Anaesth 2002; 89: 772–4

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**Posture at laryngoscopy**

Editor—The article by H.-C. Lee and colleagues is of interest to me as a teacher of trainee anaesthetists. It is a well-known fact that novice anaesthetists tend to stoop, straining their back, and look closely in the mouth, thus making visualization of the glottis more difficult (because of reduced binocular vision). Matthews and colleagues stated in 1998 that ‘One anaesthetist commented that he tells students that they need only to look in the mouth, not get into it’, and conclude that ‘We now teach students explicitly to try to stand up and stand back when attempting intubation’. Walker’s conclusion in 2002 is that ‘Novice anaesthetists should be given explicit instructions on correct trolley height and should be taught to intubate with a straight back’. I give similar advice in my book, based on years of experience.

It seems that collective memory needs reiteration with each new generation of anaesthetists.

**Declaration of interest**

I am a published author of a book on airway management (cited).

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