they would find increasing improvement of their data as the dosage of alfentanil approaches zero. Is it really necessary to administer potentially dangerous analgesics or sedative hypnotics to these elderly people for pain reported to be equal to or less than the pain of retrobulbar block? VAS = visual analog scale (0 to 10).

**Table 1. Comparison Between the Results of Our Study and Those of Yee et al.**

<table>
<thead>
<tr>
<th></th>
<th>Yee et al.</th>
<th>Our study: No sedation or GA</th>
<th>Alfentanil (20 μg/kg)</th>
<th>Methohexital (0.5 mg/kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Male:female</td>
<td>5:10</td>
<td>8:7</td>
<td>8:7</td>
<td></td>
</tr>
<tr>
<td>Mean age (yr)</td>
<td>69.60 ± 10.60</td>
<td>66 ± 7</td>
<td>66 ± 7</td>
<td></td>
</tr>
<tr>
<td>Movement score during RBB</td>
<td>15 × 0</td>
<td>12 × 0</td>
<td>12 × 0</td>
<td></td>
</tr>
<tr>
<td>Ventilatory depression score</td>
<td>15 × 0</td>
<td>12 × 0</td>
<td>12 × 0</td>
<td></td>
</tr>
<tr>
<td>Nausea (%)</td>
<td>0</td>
<td>7</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Time to discharge (min)</td>
<td>Immediately</td>
<td>45 ± 15</td>
<td>43 ± 20</td>
<td></td>
</tr>
<tr>
<td>VAS for discomfort</td>
<td>0.47 ± 0.64</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>GA = general anesthesia; RBB = retrobulbar block; VAS = visual analog scale (0 to 10).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In Response:

We wish to thank Drs. Boezaart, Boezaart, and Berry for their letter suggesting that no sedation or analgesia is needed for the placement of retrobulbar nerve block. However, there are a few points that must be considered before applying these findings to patients undergoing ophthalmic surgery (2). We also have found that there is a significant amount of painful stimulation being perceived by the patient during the placement of retrobulbar nerve block. This would indicate that there is a significant amount of painful stimulation being perceived by the patient. Furthermore, we have completed a study (which is in press) examining the dose response of alfentanil on movement during block placement. We noted that, in general, lower doses of alfentanil resulted in more movement by the patients. While we have not attempted the placement of a retrobulbar and facial nerve block without any sedation or analgesia, we believe it would be difficult to convince most patients and their surgeons to forego any sedation during this procedure. Furthermore, we believe that with adequate monitoring and vigilance patients can be safely sedated using the technique described in our paper (3) or other well-documented methods for this and other similar procedures.

James B. Yee, MD, PhD
Department of Anesthesiology
University of Utah School of Medicine
Salt Lake City, UT 84132

References


Pain on Injection of Rocuronium Bromide

To the Editor:

We read with interest the letter of Moorhy and DIerdorf (1) about pain on injection of rocuronium. With subparalyzing doses, they noticed that “most” patients had “severe burning pain” on injection of the rocuronium.

We have noted in 105 consecutive patients requiring subparalyzing rocuronium the incidence of pain on injection of the rocuronium. The site of injection, the age and sex of the patients, and the degree of pain (mild, moderate, severe) were also noted. Using $\chi^2$ tests, the relation between site of injection and pain and between the sex of the patient and the pain were analyzed. No relationship was seen between site of injection or sex of the patient and the pain on injection. Fifty-two patients of the 105 had pain on injection of rocuronium. Of these 52 patients, 13 (12%) patients had what they described as severe pain.

These results suggest that rocuronium is not suitable for use as a subparalyzing dose before succinylcholine or in priming. There should also be shown to be of little value (2.3) in speeding the onset time of rocuronium. The patient should probably be asleep before rocuronium is administered to the patient.

M. A. H. Steegers, MD
E. N. Robertson, FRCA
Department of Anesthesiology
Academisch Ziekenhuis Nijmegen
Nijmegen, The Netherlands

References


Cost-Effective Modeling

To the Editor:

Drs. Dexter and Tinker’s examination of the relationship between quality of care and reduced costs uses cost-effectiveness modeling to conclude that improving quality of perioperative care may be cost-effective only for high-risk operations (1). Although this theoretical approach to cost containment provides many insights, it is important to acknowledge the study’s limited perspective. The investigations, while focused on cost minimization for hospital care, have taken the perspective of the payer. Currently, there is increasing recognition of the importance of other perspectives, including care provider, hospital, patient, and society. Further study is needed to establish the proper role of these various perspectives in cost-effectiveness studies. For example, from the perspective of