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

	Our study: No sedation or GA	Yee et al.	
		Alfentanil (20 µg/ kg)	Methohexital (0.5 mg/kg)
<i>n</i>	15	15	15
Male:female	5:10	8:7	8:7
Mean age (yr)	69.60 ± 10.60 ^a	66 ± 7	66 ± 7
Movement score during RBB	15 × 0	12 × 0 3 × 1	1 × 0 12 × 1 2 × 2
Ventilatory depression score	15 × 0	12 × 0 2 × 1 1 × 2	12 × 0 3 × 1
Nausea (%)	0	7	13
Response to verbal commands (%)	100	87	0
Recall (%)	100	80	20
Apnea (%)	0	6.67	0
Time to discharge (min)	Immediately	45 ± 15	43 ± 20
VAS for pain during surgery	0	— ^b	—
VAS for pain during RBB	0.47 ± 0.64 ^a	0	—
VAS for discomfort during RBB	14 × 0 1 × 1	0	—

GA = general anaesthesia; RBB = retrobulbar block; VAS = visual analog scale (0-10).

^a Data are mean ± SD.

^b Not reported by Yee et al.

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 and discomfort experienced during placement of an IV cannula?

André P. Boezaart, FFA(SA)
Louis C. Boezaart, MMed(Ophth)
Roland Berry, MMed(Ophth)
University of Stellenbosch
Cape Town, South Africa

References

1. Yee JB, Schafer PG, Crandall AS, Pace NL. Comparison of methohexital and alfentanil on movement during placement of retrobulbar nerve block. *Anesth Analg* 1994;79:320-3.
2. Pivalizza EG, Abramson DC. Alfentanil and retrobulbar nerve block. *Anesth Analg* 1995;80:851.

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 this patient population in general. Previous reports have found that patients often openly express anxiety about the placement of this block (1) and that there is an increased anxiety score in nonmedicated patients undergoing ophthalmic surgery (2). We have also found this to be the case, with patients often voicing concern about receiving a "shot behind the eye" and requesting to be "asleep" during this part of their procedure. Second, it is well known that patients who are "too light" or not adequately sedated will move or wince in response to the local anesthetic injection for the retrobulbar and/or facial 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 result 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

1. McCarthy JA. Letter to the editor. *Ophthalm Surg* 1983;14:607-8.
2. Virkkila MEJ, Ali-Melkkila TM, Kanto JH. Premedication for outpatient cataract surgery: a comparative study of intramuscular alfentanil, midazolam, and placebo. *Acta Anaesthesiol Scand* 1992;36:559-63.
3. Yee JB, Schafer PG, Crandall AS, Pace NL. Comparison of methohexital and alfentanil on movement during placement of retrobulbar nerve block. *Anesth Analg* 1994;79:320-3.

Pain on Injection of Rocuronium Bromide

To the Editor:

We read with interest the letter of Moorthy 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 χ^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. Priming has also been 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

1. Moorthy SS, Dierdorf SF. Pain on injection of rocuronium. *Anesth Analg* 1995;80:1067.
2. Tryba M, Zorn A, Thole H, Zenz M. Rapid-sequence orotracheal intubation with rocuronium: a randomized double-blind comparison with suxamethonium-preliminary communication. *Eur J Anaesthesiol* 1994;11(Suppl 9):44-8.
3. Feldman SA. Rocuronium-onset times and intubating conditions. *Eur J Anaesthesiol* 1994;11(Suppl 9):49-52.

Cost-Effective Modeling

To the Editor:

Drs. Dexter and Tinker's examination of the relationship between quality of care and reduced cost 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