anesthesia on later learning abilities unless children with inguinal hernias are less likely to have other anesthetics (i.e., children with hernia are otherwise healthier than the background population, which would be difficult to argue for biologically). For clarity, as requested by Flick and Warner, we included all children in Denmark born from 1986 to 1990 who underwent surgery for inguinal hernia before the age of 1 yr (n = 2,689); of those had 2,445 (90.9%) had one hernia operation, 221 (8.2%) had two hernia operations, 20 (0.7%) had three hernia operations, 2 (0.1%) had four hernia operations, and 1 (0.0%) had five hernia operations. Our 5% randomly selected background population consisted of 14,575 individuals of the same cohort, excluding children who underwent hernia repair. Children who underwent additional surgeries were not excluded from the exposure or the control group.

We are studying the effects of multiple episodes of anesthesia (and surgery) among other children (including neonates) operated on during the first year of life. We expect this group to have bigger learning problems later in life than the background population, but it will be difficult to disentangle the effect of the more severe underlying disease(s) that prompted several episodes of anesthesia from the potential effect of multiple episodes of anesthesia. Thus, we reported on all children with hernia in our first report because they represent a group for whom the underlying morbidities are unlikely directly to affect later learning disabilities.

Finally, Flick and Warner question whether we may have missed cases in our cohort because the Danish National Hospital Register did not include outpatients before 1995. In Denmark during the period 1986–1990, all infants and young children who underwent anesthesia and hernia repair surgery with behavioral and developmental disorders in young children. J Neurosurg Anesthesiol 2009;21:286–91

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New Dreams: Back to the Future

To the Editor:

We commend Dr. Ballantyne for the excellent editorial on pain medicine that accurately and succinctly identifies the problems of pain management that arise from biomedical/technical approaches. Her call to reject “production-line medicine” and revive the multidisciplinary model challenges anesthesiologists to lead pain medicine in a new direction.

Having identified the problems, it is necessary to formulate solutions. Our medical intelligence article in ANESTHESIOLOGY comprehensively addresses the challenges and opportunities facing anesthesiologists who seek to move “beyond the needle.” Although our suggestions were not embraced at the time, they may now merit reconsideration.

Interventions and opiate medications are not fundamental modalities for the management of complex chronic pain. When administered in an appropriate context they serve as useful adjuncts that facilitate self-directed patient efforts at rehabilitation/reactivation. Used in isolation they may provide short-term benefits but create long-term problems.

The risks of interventions and opiates transcend physical complications and side effects. These treatments are powerful communications. Patients are taught that medical solutions are possible, doctors hold the power, and cure is possible if they can just find the right doctor with the right treatment. These messages are antithetical to multidisciplinary models of care based on self-management, rehabilitation, and the biopsychosocial model.

The challenge for anesthesiologists is how best to complement traditional skills and expertise to provide more comprehensive pain management services. Further progress requires that anesthesiologists learn new conceptual models of chronic pain, acquire nontraditional skills, and become comfortable in different professional roles.

Unless we adapt, we risk becoming part of the problem rather than central to the solution. For anesthesiologists to remain the dominant specialists in pain medicine it is necessary that we work within the complex world of collaborative care and patient-centered medicine. It is insufficient to limit our roles solely to technical skills. We ought to embrace new roles as physician-healers, educators, and leaders guiding the team in care of the total person.

These letters were sent to the author of the above-referenced editorial. The author felt that a reply was not necessary.—James C. Eisenach, M.D., Editor in Chief.
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References

Pain Treatment and Opioids

To the Editor:
I am really pleased to see Dr. Jane Ballantyne’s editorial “Repairing a Fractured Dream.”† I have a very personal perspective on the issue of pain and its treatment because my son was addicted to OxyContin (Purdue Pharma, Stamford, CT) and died of an overdose of oxycodone and cocaine in 2006.

After my son’s death, I realized how OxyContin especially, but also other potent prescription drugs, had become drugs of choice for many young people. They saw them as safe because doctors prescribed them. Most young people obtain the drugs from friends, who in turn get them from medicine cabinets, relatives, or doctors who, for example, would dispense large amounts for back pain. I have come to many of the same conclusions as has Dr. Ballantyne, simply by reading, talking to, and corresponding with other grieving parents and family members and learning of the vast amounts of opioids prescribed for many different conditions. Frequently I hear from friends and others about the supply of narcotic analgesics given to them after surgery. The amounts prescribed would last for weeks but are often not needed after 3–4 days.

The devastation caused by opioids affects not only susceptible people who may have a family history of addiction, but so many others who become dependent on, or addicted to, a drug prescribed to treat pain. We should be more careful. There is a presumption that opioids used to treat pain do not cause addiction, but that is simply not true.

It is encouraging that Dr. Ballantyne acknowledges the concerns with opioid treatment in general and chronic non-cancer pain in particular. My hope is that physicians and others who prescribe opioids will think carefully about the need for these medications and the amount to be prescribed.

Rosemary J. Orr, M.D., University of Washington, Seattle Childrens Hospital, Seattle, Washington. rosemary.orr@seattlechildrens.org

Reference

Intraoperative Transesophageal Echocardiography Guides Liver Transplant Surgery in a Patient with Thrombosed Transjugular Intrahepatic Portosystemic Shunt

To the Editor:
Transjugular intrahepatic portosystemic shunt (TIPS) is common in patients presenting for orthotopic liver transplantation (OLT). More than 5,200 TIPS procedures were performed in the United States in 2008.* In our institution, 18% of adult OLT recipients during the past 2 yr presented with TIPS. Whereas TIPS mitigates symptoms of portal hypertension, associated complications, such as thrombosis and migration, pose technical challenges during OLT.1–4 We present a case of OLT in a patient with known thrombosed TIPS. Intraoperative transesophageal echocardiography (TEE) revealed cephalad migration of the TIPS into the inferior vena cava (IVC) and an attached thrombus extending toward the cavoatrial junction. These findings necessitated a modification of surgical technique to safely remove the TIPS and prevent thromboembolism. We demonstrate that TEE may provide important clinical information for intraoperative management of OLT recipients with TIPS.

A 47-yr-old Caucasian man with alcoholic cirrhosis complicated by hepatorenal syndrome presented for OLT. Eight weeks earlier, he underwent uneventful placement of a 10-× 80-mm Viatorr® (Gore, Flagstaff, AZ) coated stent for refractory ascites. Four weeks later he presented with massive ascites and acute renal failure (creatinine 2.9 mg/dl) requiring urgent hemodialysis for hyperkalemia (K 7.0 mM). Abdominal Doppler revealed occluded TIPS within right hepatic vein. Magnetic resonance imaging showed only that TIPS was in place. The patient remained hospitalized requiring hemodialysis.

On the day of OLT, the patient’s Model for End-Stage Liver Disease score was 25. Intraoperative TEE (Acuson Sequoia, Oceanside, CA) confirmed absent flow within the TIPS but showed the superior end of the TIPS protruding into the IVC (fig. 1A, B) and a 2-cm thrombus extending...