In Reply—We thank Chelly et al for their interest in our case report that described major ambulatory surgery with continuous regional anesthesia and a disposable infusion pump. Although we appreciate their comments, we believe the use of continuous local anesthetic infusions at home is an investigational area of pain control. As a result, despite their institutional bias, many of the issues they highlight, such as the ideal location of catheter placement, dosing method and regimen, and appropriate patient follow-up, remain to be defined with evidence-based medicine. The case report represents a novel application of available technology to highlight the potential benefit this method could have for outpatient pain management, not a definitive treatment algorithm.

As we attempt to define an appropriate standard of care for ambulatory perineural infusion, vigilance concerning the risk of local anesthetic toxicity occurring outside of the hospital is essential. In our group, we go to great lengths to avoid such complications. The description by Chelly et al. of patients being sent home with brief instructions and a phone number is inaccurate. As we mentioned in the case report, careful patient selection is essential. In addition, at our institution, the standard of care for each patient is to receive 24-h, 7-day, and 3-week follow-up telephone calls, which are tracked in an automated database. Individual patients are also followed-up at home by physician house calls and home healthcare nurses. Deciding the level of care is based on individual clinician judgment on a case-by-case basis.

We agree with Chelly et al. that ambulatory care should provide the same level of care as in-patient care. However, we believe that ambulatory care can provide the same quality of health care as in-patient care, without the same level of nursing and medical intervention suggested by Chelly et al. Removing a continuous local anesthetic catheter at home is one example. Patients routinely remove surgical drains that lie within joint spaces and wounds without the supervision of a physician. Extending this to perineural catheters seems feasible. Furthermore, choosing the appropriate anatomic site for catheter insertion should be based on the site of surgery, patient habitus, and desired postoperative analgesia, not to simply facilitate a clinician’s ease of view of the catheter site.

The rapid growth of ambulatory anesthesia and the evolution of outpatient surgical techniques will demand that we move forward from traditional pain management strategies. This will necessitate incorporation of the numerous successful variations in community practice. Given the 50 h of postoperative analgesia provided with this technique in an ambulatory setting, the success we have seen in placing more than 1,000 continuous local anesthetic catheters for inpatient treatment in our ambulatory care unit, and the success discussed in the literature, we believe further investigation of outpatient continuous local anesthetic catheters is warranted. It is our goal to define the safety and effectiveness of this treatment method by prospective randomized trials performed by a core of professionals interested in developing this field, and not simply by individual or institutional tradition.

Nonopioid Analgesia Improves Outcomes

To the Editor—The recent article by Greif et al., highlighted in The New York Times Science section on November 9, 1999, published a reduction in postoperative nausea and vomiting (PONV) rate from 30% to 17% using supplemental postoperative oxygen. Although this would appear to be an impressive improvement, both of these rates fall well within the 15–40% PONV rate usually cited for this problem. The anesthetic regimen included the routine use of opioids in the form of 1–3 μg/kg fentanyl during induction, and more for maintenance.

Macario et al. confirmed the primacy in patients’ perspectives of the avoidance of PONV. Tang et al. recently published an article regarding the superiority of nonopioid analgesia using local anesthesia instead of opioids for reducing PONV and for greater patient satisfaction. Ponnudurai et al. recently published an article regarding the
To the Editor:—In the recent article by Grief et al., the authors state that the use of extra oxygen during and after surgery to ease anesthesia-induced nausea is “essentially risk-free.” We take exception to that statement; the use of extra oxygen during surgery is not risk free.

When extra oxygen is used during surgery, the risk of surgical fire increases. This finding is often overlooked, to the dismay of the surgical team and the injury or death of the patient. We have investigated and consulted about scores of airway fires, head and neck surgery fires, and fires during general anesthesia in which an oxygen-enriched atmosphere directly contributed to the fire. We urge anesthesiologists to use extra oxygen during surgery cautiously and only with the understanding of the entire operating team that, with the extra oxygen, there is an increased risk of surgical fire.

Please refer to the attached short reference section for further details regarding surgical fires and the hazards of oxygen-enriched atmospheres. There are many more published articles about surgical fires than the few listed herein; however, these citations are among the most noteworthy of the published information about surgical fires, and they provide much of the background and detail about the prevention of surgical fires.

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References


Use of Supplemental Oxygen during Surgery Is Not Risk Free

To the Editor:—In the recent article by Grief et al., the authors state that the use of extra oxygen during and after surgery to ease anesthesia-induced nausea is “essentially risk-free.” We take exception to that statement; the use of extra oxygen during surgery is not risk free.

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