superiority of ketamine plus local anesthesia versus alfentanil for pain relief and for ambulation.

Any study about PONV that includes the routine use of opioids may be trying to get the right answer by asking the wrong question. Avoiding the routine use of opioids, Friedberg recently published a 0.6% PONV rate in a series of 1,264 patients, one third of whom had PONV with the use of previous opioid-based anesthetics. Was Pogo right after all? Have we met the enemy, and is it us?

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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.

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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To the Editor:—We wish to comment about the article by Greif et al. \(^1\)

The authors correctly identify the many anesthetic and nonanesthetic factors that affect the incidence of postoperative nausea and vomiting (PONV). The possible beneficial effect of supplemental oxygen in preventing PONV would be of great value because antiemetic therapy, as noted by the authors, is costly and is associated with complications. However, the interpretation of the results is confused by lack of attention to specific details.

Studies of PONV demand the use of a standardized antiemetic regime\(^2\) (a variety of antiemetic agents was used in this study). This is an obvious source of bias between the groups. We know that there is a difference in PONV outcome among individual anesthetists,\(^3\) and antiemetic choice is a possible factor in this difference. If rescue therapy were at physician discretion, then the study should have ended when rescue therapy was necessary.

Pain is known to be an influence on PONV.\(^4\) Postoperative pain is significant after laparotomy. In this study, we were provided with information regarding postoperative opiate requirement, which was similar between the groups. Opiate requirement is too crude a means of assessing postoperative pain between the groups, without pain scores or information regarding other analgesics received.

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