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In Reply.—We did not claim that “the failure of simple hiccup-terminating maneuvers warrants proceeding directly to potentially damaging ‘last-resort’ maneuvers such as phrenic nerve interruption.” Instead, we fully agree with Dr. Petroianu’s claim that “the logical next step (after failure of simple maneuvers) is the use of appropriate drugs.” Our statement, “block of the phrenic nerve has been suggested as ‘the last resort’,”1,4 means that the use of this block should be considered if other less-invasive methods, including the use of potentially effective drugs, have failed. Most patients with intractable hiccup are referred from other departments in which a variety of methods, including potentially effective drugs such as baclofen, have been used in vain, although we did not describe these explicitly.

The main point we made in our report1 was not advocating the phrenic nerve block but that the use of electric nerve stimulation enables one to avoid unnecessary attempts at repeated blocks. In fact, in one of our patients,1 we judged that a successful block of the phrenic nerve would not decrease hiccup and abandoned this method. There is no “holy grail” for intractable hiccup: neither baclofen nor phrenic nerve block is always effective. The importance—we believe—is to judge whether each treatment method is effective in each patient and to stop ineffective methods at an early stage.

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Hypoxic Apnea, Epidural Anesthesia, and Infants

To the Editor.—In reviewing the recent report by Hogan et al.1 regarding hypoxic apnea in rabbits receiving epidural anesthesia, I was struck by the similarity of their report to a phenomenon seen in hypoxic newborn and premature infants: to wit, a brief hyperventilatory response followed by hyperventilation and apnea.2 In many ways, the newborn or premature infant is similar to the authors’1 rabbit-with-epidural-anesthesia model. Obviously, the blood pressure of the newborn or premature infant is much lower than that in an older child or adult. At the same time, infants exhibit primarily parasympathetic tone; this is seen in their exaggerated bradycardic responses to laryngoscopy, anesthetics, and succinylcholine, and in the absence of hypotension after pharmacologic sympathectomy with spinal or epidural anesthesia. These similarities between the rabbit-with-epidural-anesthesia model and the newborn or premature infant led me to wonder whether there might be a common mechanism for hypoxic apnea and a role for blood pressure augmentation, adrenergic agonists, or vasoconstrictors in the prevention or treatment of infant apnea.

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Unfortunately, the methods chosen by the authors do not allow us to determine whether the critical factor in hypoxic apnea is the level of sympathetic tone or simply the absolute blood pressure. It would be interesting to see whether hypoxic apnea occurs in rabbits in which hypotension is induced by a nonsympatholytic mechanism (hypovolemia, sodium nitroprusside) as well as mechanisms involving blockade of the sympathetic system (trimethaphan, epidural anesthesia) similarly, it would be interesting to see whether hypoxic apnea could be avoided in rabbits undergoing epidural anesthesia using nonsympathomimetic interventions (volume loading, vagolytics) rather than administration of adrenergic agonists. Although it is certainly possible that the critical factor is oxygen delivery to the brain, as mediated by arterial oxygen content and arterial blood pressure, the authors' methods do not rule out the possibility of specific, sympathetic modulation of respiratory drive mediated through the thoracic sympathetic system. The authors are to be commended for shedding light on the issue of unexpected cardiorespiratory arrest in patients undergoing spinal or epidural anesthesia. At the same time, their work raises provocative questions about apnea in infants and control of respiratory drive.

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Predicting Long-term Postoperative Cardiovascular Outcomes

To the Editor—Referring to the article of Badner et al., Dr. Mangano encourages assessment of the value of perioperative observations and interventions for predicting quality of life, event-free survival, and cost. Badner et al. further this goal by relating postoperative signs and symptoms to longer-term risk of myocardial infarction (MI) and associated mortality. This valuable data set could provide even further insight into the risk profile for MI and MI-related mortality among surgical patients by a more complete analysis of the available information.

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