represent a contraindication for metformin medication (insufficiency of cardiovascular, pulmonary, or renal function; infections; catabolic metabolism) does not differ significantly if operations of the same size are performed in regional anesthesia. In case of ambulatory surgery we have concerns, and the development of contraindications might proceed unnoticed.

Although we agree with Lusitik et al. regarding the importance of good diabetic control, we prefer to continue our rather restrictive practice of perioperative metformin therapy. Sodium dichloracetate (DCA), as proposed by Preiser and Vincent, could be an interesting future option for the therapy of lactic acidosis, especially because it could provide more than just symptomatic therapy.

However, DCA does not belong to the standard therapy of biguanide-induced lactic acidosis. Further, the clinical trials Preiser and Vincent refer to do not suggest DCA to be a magic bullet. Because metformin-induced lactic acidosis is a rare phenomenon and our personal experience is limited, we did not consider a therapy besides the recommended standards in this case.

**Hinrich Wulf, M.D.**  
**Stephanie Mercker, M.D.**  
**Christoph Maier, M.D.**  
**Günther Neumann, M.D.**  
Klinik für Anästhesiologie und Operative Intensivmedizin der  
Chr.-Albrechts-Universität Kiel  
Schwanenweg 21  
D-24105 Kiel  
Germany  
wulf@anaesthesie.uni-kiel.de

(Accepted for publication February 23, 1998.)
ward, nor did they include the period after the patients were discharged to the ward in the observation period. Therefore the burden of proof that Dr. Lubarsky et al.’s patients did not experience clinically significant residual block that might have adversely influenced outcome still rests with the authors.

Jorgen Viby-Mogensen, M.D., D.M.Sc., F.R.C.A. 
Professor and Chairman
Department of Anesthesia and Intensive Care 
Copenhagen University Hospital 
Rigshospitalet 
DK-2100 Copenhagen 
Denmark 
viby@rh.dk

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Pharmaceutical Practice Guidelines: Do They Actually Cost Money?

To the Editor:—Lubarsky1,2 dismisses the concerns of Riley3 and Bailey and Egan1 who question the magnitude of savings that would be attained using Lubarsky et al’s pharmaceutical practice guidelines.5 When Riley noted that a 3-min increase in "emergency time" would increase costs at his institution, Lubarsky replied that this cost would be incurred only at Riley’s institution. However, the same increased costs would be incurred at our hospital (and possibly others), in which nurses chronically work overtime. In addition, Lubarsky dismisses a 3-min savings as not detectable by an accounting system. We doubt this. As an analogy, if General Motors could shave 5 min off the production time for each vehicle, it would certainly do so!

Similarly, Lubarsky claims that Riley is "mistaken in his analysis of the one case of prolonged mechanical ventilation resulting from pancuronium administration" because the difference in incidence of adverse events "was not any different before versus after the implementation of practice guidelines." Although he is correct, he should acknowledge that his study is underpowered for detecting an increased incidence of severe (and potentially extremely costly) adverse events.

A more important issue has been completely ignored by Lubarsky et al. in their economic analysis. If anesthetists are under pressure to reduce costs, so are surgeons (and other operating room personnel). In our institution (which is presumably similar to Lubarsky’s), surgical attendings are now present during a larger percentage of the procedure than in past years, and skin closure is no longer delegated to undersupervised medical students. In support of this, Macario et al.6 recently reported that operating room costs for pa-