CORRESPONDENCE

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In Reply.—Kron’s assertion that the results of our study suggest a 75% failure rate of cricoid pressure in preventing aspiration as documented by the presence of new infiltrates on chest radiograph is in error. As stated in the manuscript, the 272 patients with chest radiographs to evaluate, 24 had evidence of new infiltrates. Twelve of these had preintubation evidence of aspiration. Thus, 12 patients presumably aspirated during the procedure. (It is possible that some of these patients aspirated before intubation). Nine of these 12 patients had cricoid pressure applied during the procedure. However, 248 patients did not aspirate during intubation. Of these patients, almost 90% were considered at risk for aspiration and had cricoid pressure applied during the procedure. Thus, there was an almost 95% success rate of preventing aspiration with the use of cricoid pressure during intubation in critically ill adults.

Our study was not designed to be a prospective, randomized study of the efficacy of cricoid pressure in preventing aspiration in critically ill adults. Such a study would involve obtaining a chest radiograph immediately before intubation and randomizing patients to two groups: One group would have cricoid pressure applied during the procedure; the other would not. Such a study is impractical and dangerous and, we believe, should not be done. We also believe that the application of cricoid pressure is operator-dependent and that health-care workers should have instruction in its proper use. Improper application of cricoid pressure might explain any failures. The use of cricoid pressure to protect the airway in patients at risk for aspiration during the induction of anesthesia and intubation of the trachea is and should remain the standard of care.

Is the glass half full or . . . ?

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Reference


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PEDIATRIC PAIN SERVICES: MONITORING FOR EPIDURAL ANALGESIA IN THE NON-INTENSIVE CARE UNIT SETTING

To the Editor.—We conducted a survey of pediatric anesthesia services in the United States and Canada to determine which provide epidural analgesia on inpatient floors and what routine monitoring practices are used. Pediatric services with more than 100 beds were identified from the 1992 Manual of the National Association of Children’s Hospitals and Related Institutions. A member of the pain service or a pediatric anesthesiologist was interviewed by phone. If any modality of epidural analgesia (single-dose opioid, intermittent bolus opioid, or continuous infusions of local anesthetic and opioid) was used on the floors, the monitoring survey was completed. The survey consisted of three questions: What continuous monitors (pulse oximetry, capnography, or electrocardiogram) are routinely employed? Which intermittent evaluations (respiratory rate, sedation score, and pain score) are recorded? What is the initial interval between intermittent evaluations?

Seventy-three institutions were eligible for the survey. Fifty-three (75%) interviews were completed. Of the surveyed institutions, 26 had more than 200 pediatric beds and 27 had less than 200 pediatric beds. Of the surveyed institutions, 40 (75%) provided epidural analgesia to children on the inpatient floors. The results of the survey are presented in tables 1 and 2.

Of hospitals that provide epidural analgesia on regular inpatient units, 92% routinely use continuous monitoring. Continuous monitoring with pulse oximetry alone or combined with capnography was most prevalent (table 1). Respiratory rate is assessed and recorded every hour in 85% of the institutions providing epidural analgesia on the sedation score. Pain level is to be recorded either hourly on a pain score scale or on a 0-10 scale.

Table 1. Continuous Monitors Used in 73 Institutions Providing Epidural Analgesia

<table>
<thead>
<tr>
<th>Institution</th>
<th>Sedation Score</th>
<th>Pain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>73 institutions</td>
<td>85%</td>
<td>85%</td>
</tr>
</tbody>
</table>

Table 2. Intermittent Parameter Monitoring

<table>
<thead>
<tr>
<th>Institution</th>
<th>Respiratory Rate</th>
<th>Sedation Score</th>
<th>Pain Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>73 institutions</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
</tr>
</tbody>
</table>

Pediatric Pain Services: Monitoring for Epidural Analgesia in the Non-Intensive Care Unit Setting

Anesthesiology, V 83, No 2, Aug 1995

Patient-controlled analgesia (PCA) is used routinely to control analgesia in patients at risk for perioperative pain. In Florida, we find . . .

To the Editor.—Correspondence...
CORRESPONDENCE

Table 1. Continuous Monitors Routinely Used on Inpatient Floors (%)

<table>
<thead>
<tr>
<th>Institutions</th>
<th>Oxiometry Only</th>
<th>Oxiometry/Apnea</th>
<th>Oxiometry/Electrocardiogram</th>
<th>Apnea Only</th>
<th>Apnea/Electrocardiogram</th>
<th>All</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>All (n = 40)</td>
<td>37.5</td>
<td>30</td>
<td>7.5</td>
<td>7.5</td>
<td>5</td>
<td>5</td>
<td>7.5</td>
</tr>
<tr>
<td>&lt;200 beds (n = 17)</td>
<td>41</td>
<td>29</td>
<td>6</td>
<td>12</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>&gt;200 beds (n = 23)</td>
<td>35</td>
<td>30</td>
<td>9</td>
<td>4</td>
<td>9</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>

Institutions providing epidural analgesia on inpatient units. The initial recordings of the sedation score, pain assessment, and other vital signs tend to be recorded either hourly or at 4-h intervals. Twenty-seven percent of surveyed institutions do not routinely record pain scores (table 2).

Epidural analgesia is used routinely for children in non-intensive care unit settings. The hourly recording of respiratory rate and the use of continuous monitors are common. The specific choice of continuous monitor(s) and recording of other parameters shows variability of practice, despite the existence of monitoring guidelines. Consensus-based practice guidelines should be developed to ensure the safety of children receiving epidural analgesia in non-intensive care unit settings.

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To the Editor.—Correspondence from Ready examined the use of patient-controlled analgesia (PCA) in the United States.1 As an extension to his useful work, it would be helpful to have additional data regarding PCA management in elderly postoperative patients, who are at greater risk for perioperative problems than the general population.1 In Florida, we find little management of postoperative PCA by anesthesiologists. Perhaps this is because of the relatively large percentage of Medicare patients in our state and because of the decision of the Health Care Financing Administration (HCFA) to halt further Medicare reimbursement to Florida anesthesiologists for this service, effective June 1, 1992. The HCFA’s position is that surgeons have historically managed patients’ postoperative pain and that they should continue to do so “except under special circumstances,” with pain management reimbursement thus part of the surgeon’s global fee.1 Our opinion is that this conclusion by HCFA is erroneous, because no one managed postoperative pain until anesthesiologists recently defined a new standard and began to focus their attention upon it.1

PCA is commonly thought of as an “autopilot” process, and thus there is no need for specialized acute pain service management.