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of the laryngeal mask airway. Although using the SIB in no way precludes the appropriate clinical assessment of adequate ventilation, i.e., bilateral breath sounds, we believe the ability of the SIB to facilitate the proper positioning of the ET warrants its use.

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Ondansetron or Metoclopramide in Children Undergoing Tonsillectomy

To the Editor.—Furst and Rodarte1 recently reported that 0.15 mg/kg intravenous ondansetron is highly effective in reducing posttonsillectomy vomiting in children and that droperidol and metoclopramide are not effective. These data are significant because droperidol and metoclopramide have been reported to be effective prophylactic antiemetics in children.2–5 However, contrary to the authors’ introductory statement that “no studies to date have examined the use of ondansetron in children for the prevention of postoperative emesis,” numerous clinical investigations and abstracts on this subject are published.6–7 In one of these reports, 0.15 mg/kg intravenous ondansetron is reported to decrease vomiting after tonsillectomy in children from 73% (of the placebo group) to 23% (of the ondansetron group).8

In addition, we question a premise of their experimental design. Specifically, the authors state that the dose of metoclopramide used in their study (0.5 mg/kg intravenously) was “selected from the literature” and has been shown effective in preventing postoperative emesis in children at high risk for this complication. However, in none of the references to this claim has the use of this dose of metoclopramide been studied in healthy children undergoing surgery.

The authors attempt to further justify this relatively large dose of metoclopramide by stating that doses as large as 5 mg/kg intravenously are used for the prevention of chemotherapy-induced vomiting.9 The authors fail to mention that this dose of metoclopramide (3 mg/kg intravenously) was part of an antiemetic regimen that included 25–50 mg intravenous diphenhydramine, decadron, and lorazepam. In another article coauthored by Furst and Rodarte, they state a reluctance to use more than 0.25 mg/kg metoclopramide because of the potential for extrapyramidal side effects.5 Has the safety and efficacy of 0.5 mg/kg intravenous metoclopramide in children during the perioperative period been established? If not, were parents of subjects in this study apprised of the experimental nature of this dose of metoclopramide?

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In Reply—Three of the four citations referred to by Rose and Martin are abstracts.1,3−5 As is the one we authored.2 We did not believe that work published in abstract form qualified as proper studies in that the peer review process associated with their publication is much less thorough and the validity of the conclusions is a very tentative nature. The editorial staff of Anesthesiology appear to agree, as the Guide for Authors for Anesthesiology states that “abstracts are acceptable as references only if published within the previous 3 yr in an indexed journal.” The remaining reference was published in March 1994.6 Our original manuscript was submitted in 1993, and the final revision was submitted in March 1994. If we had been aware of this article, we would have rephrased that sentence.

With regard to the dose of metoclopramide used, we indeed stated in a previous article that “we were reluctant to increase the dose because of the potential for extrapyramidal effects.”6 However, that referred to the dose we chose for that study and clearly points out the fact that we care about the well-being of our study patients. The patients had no dystonic reactions at the dose of 0.25 mg/kg, and as stated in the same article, “Although the benefit observed was not statistically significant at the lower dose studied (0.15 mg/kg), it became so at the higher dose (0.25 mg/kg), suggesting a dose-response relationship. Whether higher doses will prove more efficacious remains to be determined.”6 We believed that, for the best chance for metoclopramide to be effective, it was worth administering a higher dose and monitoring for side effects, which, in the unlikely event that they occurred in a significant number, could have led to a reevaluation of the protocol. No episodes of extrapyramidal effects occurred. We were prepared to use the dose of 1 mg/kg diphenhydramine that the nurses administer routinely for patients who are experiencing extrapyramidal effects. (In our hospital, these events usually are associated with droperidol administration ordered by the surgical house staff.) Although Grunberg and Hesketh7 administered other drugs in combination with metoclopramide in their protocol, at least one other study used doses as high as 5 mg/kg without the routine administration of diphenhydramine. In that study of 135 patients, the incidence of extrapyramidal effects was 2.2%, an acceptable number in view of the fact that our dose was an order of magnitude less. In another study,7 bolus doses of 2 mg/kg metoclopramide up to a total of 10 mg/kg were given over an 8.5-h period. One of the 41 patients (2.4%) in that trial had extrapyramidal effects requiring treatment.

The parents of our patients were fully informed. The dose and risk of side effects were reviewed thoroughly by our institutional review board, which is chaired by a pediatric pharmacologist.

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References


