management modality. The effect of any treatment modality on hospital stay is valid only when discharge criteria are standardized and enforced by an independent blinded observer.

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Postoperative Pulmonary Complications: II

To the Editor—Although the recent study by Jayr et al.¹ used superb statistical design, the clinical design indeed has some shortcomings.

First, the morphine dose used in their protocol is significantly less than expected. Our group has demonstrated in 2,843 opioid-naïve cancer surgical patients that mean epidural morphine use during the first 5 postoperative days decreased from 0.6 to 0.16 mg·h⁻¹.² All patients received 0.1% bupivacaine and 0.01% morphine sulfate via continuous epidural infusion and still required intravenous breakthrough doses of morphine of 6, 4, and then 0 mg·day⁻¹. Since Jayr and collaborators used one third of our morphine dose (0.25 mg·h⁻¹) during their study, it is likely that less than adequate pain control was achieved requiring high breakthrough doses of paracetamol. Unfortunately, important information regarding daily paracetamol use is not included. Their study conceivably is not comparing epidural with parenteral therapy, but perhaps intravenous paracetamol versus subcutaneous morphine therapy.

Second, the number of patients who underwent either upper or lower abdominal surgery in each group and the type of incision used was not mentioned even though it was reported that upper abdominal procedures were performed via midline or biconal (chevron) incisions. Since biconal incisions transect the rectus abdominis muscles, the degree of postoperative pulmonary dysfunction would be greater in this group of patients and is vital information for drawing conclusions regarding the final outcome.

Third, the authors concluded that epidural analgesia did not result in a reduction in the length of hospital stay. If 90% of the epidural group, versus 70% in the parenteral group, had recovered intestinal function (fig. 6) by the 5th postoperative day, one can assume that oral intake occurred by the 8th postoperative day. Why were both groups kept in the hospital 10 more days? Moreover, the protocol did not control the time at which patients were to be discharged, so this conclusion cannot be obtained correctly from their data. We can agree only with their conclusion that epidural analgesia did not decrease the incidence of postoperative pulmonary complications, in these 153 patients under the published study conditions. However, it is clear that little extrapolation can be made to assist in perioperative clinical anesthetic selection for high-risk surgical patients.

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References


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