CORRESPONDENCE

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In Reply—I agree with most of the points made by Levin and colleagues. They point out that our patient may not have experienced near-fatal respiratory distress if we had 1) not used a basal infusion or if we had used much less than 2 mg/h; 2) programmed a 1- or 4-h limit on the amount of opiate delivered; and 3) monitored the patient more closely. All of these points were made in the last paragraph of our article and are worth repeating.

The authors state that a 1- or 4-h limit should be set at 20–30% of the “calculated dose.” Although this would certainly provide a greater margin of safety, I am not sure that it would meet the needs of most patients. During periods of stimulation, e.g., dressing changes and transport to and from procedures, patients often will deliver boluses as often as possible in order to control their pain. A 20–30% limit could easily leave these patients without analgesia for prolonged periods. This may cause the patient’s primary physician either to order supplemental injections or to reject patient-controlled analgesia (PCA) altogether.

Our intent in publishing our case report was not to discourage the use of PCA but rather to suggest caution when dealing with obese patients, particularly those who may have obstructive sleep apnea syndrome.

PCA pumps capable of being programmed in a sophisticated interactive fashion are on the horizon. These pumps will have the potential to modify dose and frequency based on time of day and the patient’s past record of drug demands and delivery. Such systems may help in optimizing the use of PCA; however, the need for vigilance and the development of sound clinical judgement will continue to be our best safeguard.

D. H. VAN DER CAR, M.D., PH.D.
Senior Resident
Department of Anesthesiology
University of Miami/Jackson Memorial Hospital
1611 N.W. 12th Avenue
Miami, Florida 33136

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On the Pressure Rate Quotient

ANTONIO BOBA, M.D.
587 Albany Post Road
Hyde Park, New York 12538

REFERENCES


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