A Postoperative Pain Management Service

To the Editor:—Ready et al. propose that ASA physical status 1 and 2 patients under 50 yr of age receiving 6 mg epidural morphine or less be managed on routine wards under the care of specially trained nurses but without the mandatory use of respiratory monitors. An accompanying editorial warmly supports the use of epidural opiates and goes on to state, “We need to know whether patients receiving epidural opiates can be safely cared for in a regular nursing ward, or whether a special care unit is necessary.” I suggest we have ample evidence from volunteer studies and from reported problems with patients that the superabundance of opiates is not safe without the combined resources of skilled nursing personnel, effective apnea monitors, and continuous monitoring of gas exchange, preferably in special pain-management units.

As Ready et al. point out, respiratory rate is not a reliable predictor of respiratory depression, apneic intervals, or impending respiratory failure, whether in patients or athletic unmedicated volunteers. Serious “near misses” have been reported in high-intensity nursing areas when reliance has been placed on human monitors alone, while tragedy has been more comfortably averted by monitors alerting nurses in near, but not close, proximity.

Marketplace forces and competition for patients may make us unwilling to accept the unpalatable evidence that the dangers of intraspinal opiates are expensive to contain, but contained they must be. Accumulating evidence leaves no doubt that all intraspinal opiates may produce sudden respiratory arrest, and the only safe and ethically acceptable way to handle them is with the appropriate back-up systems operating throughout the danger period, whatever the patient’s age and physical status.

Professor of Anesthesia

References

2. Saidman LJ: The anesthesiologist outside the operating room: A new and exciting opportunity. Anesthesiology 68:1–2, 1988

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