for its respiratory-depressant effect eliminates individual variability and the possibility for prolonged respiratory depression.

Our usual sequence involves administering 8–12 mg of methadone to the awake patient until the threshold for respiratory depression (respiratory rate of 6–8/min) is reached. An additional bolus of methadone amounting to half the initial dose then is given just before the incision. Using this method of administration we have obtained clinical results similar to those observed by Gourlay et al. and have had no instances of excessive respiratory depression postoperatively. We believe that this is a superior method of administration for methadone and one that is necessary, given the prolonged half-life of the drug.

In reply.—The clinical experience of Wangler and Rosenblatt, with regard to prolonged postoperative analgesia with methadone, is similar to that reported in our ANESTHESIOLOGY article. We also have not observed any significant respiratory depression following a 20-mg intravenous bolus dose administered after induction of anesthesia as previously reported. However, we share the concern expressed by Wangler and Rosenblatt for the potential prolonged respiratory depression following large methadone doses, and we support the need for a titration method. This is particularly important in the situation where the initial dose is insufficient for adequate pain control and supplementary doses of methadone are required.

We recently have completed a further study (submitted) in which supplementary intravenous methadone doses (5 mg) were administered in the immediate postoperative period (in addition to the 20 mg of methadone intraoperatively) when the following criteria have been satisfied:

1. The patient complained of significant postoperative pain,
2. No significant respiratory depression (rate less than 10 breaths/min) was observed, and
3. There was no marked depression of the level of consciousness.

We elected to use the intravenous route because there is complete bioavailability, and the pharmacodynamic response can be monitored immediately. Our previously reported pharmacokinetic data indicate that the mean distribution half life is 6 min and therefore at least 30–40 min (that is five to six times the distribution half-life) should elapse between supplementary doses so that a thorough assessment of the previous dose can be made. One to three additional 5 mg intravenous doses have been administered in the Recovery Ward to achieve satisfactory analgesia to a series of patients undergoing surgical procedures involving upper abdominal incisions. The duration of analgesia from the time it was achieved by titration of additional methadone doses was similar to that in our previous report (mean SD 21 ± 13 h). A further 5 mg methadone dose administered when pain returned after this resulted in an adequate analgesia for a similar duration. Under these conditions there was no significant respiratory depression assessed by measuring unstimulated respiratory rate.

Wangler and Rosenblatt and our group independently have arrived at essentially similar titration methods with minor differences in the dose of methadone administered and the time of administration. In addition, our recent results suggest a safe and effective method of administering additional methadone postoperatively, should this be indicated.

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