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## Postoperative Care following Intrathecal or Epidural Opioids. II.

*To the Editor:*—We read with interest the recent report documenting the use of small doses of intrathecal morphine for analgesia following transurethral resection of the prostate.<sup>1</sup> We would like to know whether the authors think intensive care facilities and mechanical respiratory monitors are necessary for the routine use of this technique. It is our contention that treatment of postoperative pain can be safe using epidural and intrathecal opioids without the added costs of highly specialized nursing units or mechanical devices to monitor ventilation.

Details vary from institution to institution, but the essential elements required for safe administration of intraspinal opioids on a routine basis are the same:

- 1) Careful patient selection with modification of opioid doses for patient age and physical status.
- 2) Regular follow up by skilled and knowledgeable physicians.
- 3) Sound education of all nursing personnel regarding the use and risks of intraspinal opioids including instruction in bedside monitoring techniques which ensure early detection of respiratory depression.
- 4) Provision for periodic nursing education updates.
- 5) The use of printed protocols and standard orders developed jointly by physicians and nurses to govern the use of intraspinal narcotics, including those permitting immediate intervention by nurses, if necessary.
- 6) Provision of a support system within the hospital which is capable of providing immediate airway management and ventilatory support at all times.
- 7) Continuing quality assurance review of all problems.

Following these principles, it can be argued that intraspinal opioids are as safe as intramuscular injections on hospital wards. Over 6,000

patients have safely been treated with epidural or intraspinal morphine in our institutions. There have been no deaths or injuries attributable to the use of intraspinal opioids. We believe that the burgeoning and expensive technology of apnea monitors adds only expense to patient safety, which is better provided by the most discriminating of monitors—the nurse observing the patient. Nursing time need not be increased. Patients are observed in the usual course of nursing care, but on a scheduled, ordered basis. We should not allow a nonexistent problem to drive up costs or deter us from providing the best possible postoperative pain control.

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### REFERENCE

1. Kirson LE, Goldman JM, Slover RB: Low-dose intrathecal morphine for postoperative pain control in patients undergoing transurethral resection of the prostate. *ANESTHESIOLOGY* 71: 192–195, 1989

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*In Reply:*—We share Dr. Ross's concern regarding increased cost of monitoring patients who have received intraspinal opioids. We did not intend to suggest that all patients receiving intrathecal morphine require admission to an intensive care unit. Our patients were placed in surgical intensive care not only for monitoring but for standardization of certain aspects of the study protocol. Intraspinal opioids have gained widespread use for a variety of surgical procedures performed on patients who are returned to their surgical ward postoperatively. As suggested by Ready and Edwards, such policy demonstrates that ward nurses, after appropriate training and experience, can safely monitor these patients.

We stated in our paper that complications involving the respiratory status of patients appear to decline as the dose of intrathecal morphine decreases. Therefore, the primary goal of our study was to establish if a very low dose of intrathecal morphine would be effective in eliminating postoperative pain in a specific surgical procedure. We hope that the data generated by this study, when considered with information gathered from other studies, helps in establishing correct and safe

guidelines for monitoring of all patients who have received intraspinal opioids.

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