Table 1. Continuous Monitors Routinely Used on Inpatient Floors (%)

<table>
<thead>
<tr>
<th>Institutions</th>
<th>Oxymetry Only</th>
<th>Oxymetry/Apnea</th>
<th>Oxymetry/Electrocardiogram</th>
<th>Apnea Only</th>
<th>Apnea/Electrocardiogram</th>
<th>All</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>All (n = 40)</td>
<td>37.5</td>
<td>30</td>
<td>7.5</td>
<td>7.5</td>
<td>5</td>
<td>5</td>
<td>7.5</td>
</tr>
<tr>
<td>&lt;200 beds (n = 17)</td>
<td>41</td>
<td>29</td>
<td>6</td>
<td>12</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>&gt;200 beds (n = 23)</td>
<td>35</td>
<td>30</td>
<td>9</td>
<td>4</td>
<td>9</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>

Institutions providing epidural analgesia on inpatient units. The initial recordings of the sedation score, pain assessment, and other vital signs tend to be recorded either hourly or at 4-h intervals. Twenty-seven percent of surveyed institutions do not routinely record pain scores (table 2). Epidural analgesia is used routinely for children in non-intensive care unit settings. The hourly recording of respiratory rate and the use of continuous monitors are common. The specific choice of continuous monitor(s) and recording of other parameters shows variability of practice, despite the existence of monitoring guidelines. Consensus-based practice guidelines should be developed to ensure the safety of children receiving epidural analgesia in non-intensive care unit settings.

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To the Editor.—Correspondence from Ready examined the use of patient-controlled analgesia (PCA) in the United States. As an extension to his useful work, it would be helpful to have additional data regarding PCA management in elderly postoperative patients, who are at greater risk for perioperative problems than the general population. In Florida, we find little management of postoperative PCA by anesthesiologists. Perhaps this is because of the relatively large percentage of Medicare patients in our state and because of the decision of the Health Care Financing Administration (HCFA) to halt further Medicare reimbursement to Florida anesthesiologists for this service, effective June 1, 1992. The HCFA’s position is that surgeons have historically managed patients’ postoperative pain and that they should continue to do so “except under special circumstances,” with pain management reimbursement thus part of the surgeon’s global fee. Our opinion is that this conclusion by HCFA is erroneous, because no one managed postoperative pain until anesthesiologists recently defined a new standard and began to focus their attention upon it.

PCAs are commonly thought of as a “autopilot” process, and thus there is no need for specialized acute pain service management.


Anesthesiology. V 83, No 2, Aug 1995
CORRESPONDENCE

However, is this true? We have believed that PCA was just as management-intensive as epidural analgesia and that anesthesiologists were the ideal providers of PCA because of their knowledge of pain physiology and their command of the analgesic armamentarium, including the utilization of parenteral opioids and the treatment of their side effects and complications.6 Our impression of PCA management intensity was confirmed by a pilot study. We noted that PCA has just as many side effects and requires just as many ward nurses and acute pain service interventions as does epidural analgesia.7 In addition, the common assumption that PCA possesses less risk than epidural analgesia is unwarranted. There is no evidence that respiratory depression, the most dangerous side effect of opioid administration, occurs less often with PCA relative to epidural administration.6

No one questions the need for anesthesiologists to manage epidural analgesia; but if PCA is equally problematic and equally management-intensive, anesthesiologists should likewise be reimbursed for this service. And in the case of postoperative epidural analgesia, how much of the overall benefit is derived exclusively from the epidural infusion per se, and how much is the result of other undefined aspects of twice-a-day acute pain service rounds? We do not believe that we are unnecessarily fixated on dollars. The decision of the HCFA not to reimburse anesthesiologists for postoperative PCA pain management has impeded optimal postoperative pain management—anesthesiologists are the optimal providers of PCA, and yet it is realistic to assume that, if they are not reimbursed for this service, they are unlikely to assume its burden. Our department has decided to continue to manage all PCA, including postoperative, because we are convinced that this is what is best for our patients and because our group practice situation allows us to do so with minimal individual financial repercussion. For a variety of reasons, however, many other anesthesiology departments have not been so inclined. For optimal postoperative PCA management, HCFA Medicare reimbursement policies should support the recently published U.S. Department of Health and Human Services acute pain management guidelines, which state that, "in all cases, responsibility for acute pain management should be assigned to those most knowledgeable, experienced, interested, and available to deal with the patients' needs in a timely fashion."

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References


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Pharyngeal Packs Can Cause Massive Swelling of the Tongue after Neurosurgical Procedures

To the Editor.—Massive swelling of the tongue has been reported after neurosurgical procedures.1-4 Mechanical obstruction of venous and lymphatic drainage of the tongue due to prolonged flexion of the neck and use of an oral airway and tracheal tube has been suggested as a possible cause of massive swelling of the tongue. Recently, we managed a patient who underwent tracheotomy and removal of

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