

Anesthesiology
83:1132, 1995
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Role of Epidural Anesthesia and Analgesia on Postoperative Patient Outcome

To the Editor:—The article by Liu *et al.*¹ provided a comprehensive review of the existing studies investigating the role of epidural anesthesia and analgesia on postoperative patient outcome. The discussion on the effects on the cardiovascular system, however, is misleading in that the authors did not differentiate between the studies of patients undergoing cardiac *versus* noncardiac surgery. Specifically, on page 1479, the authors cited that “intensive perioperative analgesia with large doses of systemic opioids can reduce myocardial morbidity and mortality.”^{2,3} Furthermore, the authors cited that “myocardial infarction commonly occurs on the 3rd or 4th day after surgery, suggesting that aggressive therapy may need to be extended for at least 4 days.” The extrapolation of results from the two studies from cardiac to noncardiac surgery is not warranted. The study by Anand and Hickey² was performed in patients undergoing cardiac surgery for congenital cardiac defects, whereas the study by us was performed in patients undergoing coronary artery bypass graft surgery, when the use of intensive analgesia was shown only to reduce the severity of certain electrocardiographic ST-segment changes.³ In this latter study, neither the incidence of myocardial ischemia nor the myocardial infarction rate (the study lacks power to determine whether there was a difference in infarction rate) differed between postoperative management techniques.

The etiology of why patients suffer postoperative myocardial infarction after cardiac surgery is likely to be very different from that after noncardiac surgery. To imply that one type of postoperative pain management or one type of prophylactic antiischemic therapy can suppress or eliminate postoperative cardiac complications is clearly an oversimplification. The mechanisms of postoperative myocardial ischemia or myocardial infarction are likely to be multifactorial when different clinical therapies must be employed. Furthermore, myocardial infarction after cardiac surgery typically occurs immediately after the procedure, with elevation of CPK-MB cardiac isoenzymes within the first 24 h after surgery and the appearance of

Q waves on postoperative 12-lead electrocardiogram by the 1st postoperative day.⁴ Therefore, the time course of the occurrence of myocardial injury is different from that of noncardiac surgery. Ensuring that “postoperative analgesic regimen to be scientifically sound” as proposed by the authors would involve understanding the physiology of perioperative myocardial ischemia and infarction, an, as yet, unattained goal.

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(Accepted for publication August 10, 1995.)

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83:1132–1133, 1995
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Should Renaming the Specialty Begin with the Journal?

To the Editor:—I was privileged to have heard in person the 33rd Rovenstine Lecture delivered by Lawrence Saidman, M.D., at the 1994 meeting of the American Society of Anesthesiologists and was grateful to see its text published in *ANESTHESIOLOGY*.¹ A major portion of the

lecture was devoted to a discussion of whether the name “anesthesiology” best serves the physicians who practice our medical specialty. As the breadth of our discipline has grown to encompass patient assessment and care beyond the intraoperative period and we have