Recently, the manufacturer of Diprivan published an article presenting its view on safety of propofol as well as the pathophysiology of propofol infusion syndrome. This report mentions the above-presented trial, but unfortunately lacks further relevant information from this.

This leads to two serious problems. First, without presentation of all data from trial 0859IL-0068, an interpretation of the results from this study and especially the mortality rates is significantly limited. Second, additional studies as proposed by Wysowski and Pollock may be impossible from an ethical point of view.

Therefore, the complete information from trial 0859IL-0068 should be submitted to a peer-reviewed journal to enable presentation of all relevant data and to have the chance to get more insights into the effects and safety of propofol in (pediatric) intensive care medicine.

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References

1. Wysowski DK, Pollock ML: Reports of death with use of propofol (Diprivan) for nonprocedural (long-term) sedation and literature review. Anesthesiology 2006; 105:1047–51

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To the Editor—I read with interest the report by Michelet et al. for many years, hypoxemia was considered as the most important—if not the only—problem during one-lung ventilation (OLV). Therefore, the guidelines are primarily aimed at preventing and treating the hypoxemia. Since Katz et al. found that large tidal volumes produced the highest arterial oxygen tension (PaO2) during OLV, one can find in these guidelines that the tidal volume during OLV should be kept as high as in two-lung ventilation (i.e., 8–10–12 ml/kg).

However, recent studies have shown that the lung injury after thoracotomy is also an important challenge in lung surgery, and the ventilatory setting (especially during OLV) is probably associated with this injury. So, a revision of the classic guidelines has been necessary. This article is indeed an important step in this revision after some in vitro and in vivo studies. However, in contrast to the current study, in the study of Schilling et al., decreased tidal volumes were associated with a (statistically insignificant) decrease in PaO2 levels during OLV. This contrast may be a result of the fact that there was no positive end-expiratory pressure (PEEP) application in the control group in the current study. In several studies, it has been shown that PEEP was associated with an increase in oxygenation compared with zero end-expiratory pressure without any other change in ventilatory setting. So, PEEP should be considered as a prevention/treatment strategy both against hypoxemia and against lung injury. Furthermore, information about and comparison of the number of the patients in each group in whom the fraction of inspired oxygen has been increased to treat arterial hypoxemia would also be necessary.

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References

1. Wysowski DK, Pollock ML: Reports of death with use of propofol (Diprivan) for nonprocedural (long-term) sedation and literature review. Anesthesiology 2006; 105:1047–51

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