

facile clinicians and practice management experts. They are also inspiring educators, able to teach patients and their families, physician peers, and the vast array of paraprofessional hospital staff about anesthesiology. As individuals who champion anesthesia patient care, clinician practitioners are astute observers of much that we do not understand. Dr. Serlin, sit on the anesthesiology stool by asking the questions about what we do not understand about anesthesiology and make the choice to investigate the answers by reallocating your time and resources.

Alan Jay Schwartz, M.D., M.S.Ed., Children's Hospital of Philadelphia, Philadelphia, Pennsylvania.
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(Accepted for publication April 20, 2010.)

Procedure-specific Guidelines

To the Editor:

A recent article on how to improve postoperative pain management states that an epidural is "clearly not appropriate for open hysterectomy."¹ This statement seemed unusual to us, especially considering that one of the authors has previously published articles promoting the benefits of neuraxial block for hysterectomy.²⁻⁷ On the basis of some of these prior studies, a low thoracic epidural together with a propofol infusion seems appropriate for the patient who is anxious about vomiting or those who cannot tolerate "pain medicines." Table 1 in this recent article¹ recommends local anesthetic wound infusion for this procedure, but that fails to address opioid use during the procedure.

Hysterectomy is not a single entity. Some hysterectomies can entail lymph node dissections that involve midline incisions above the umbilicus, while others involve very small Pfannenstiel incisions. Likewise, epidural anesthesia is not a single entity. The catheter can be placed in the lumbar or thoracic interspaces, and the drugs and drug combinations are numerous. Indeed, the cited Web site* quotes several unconventional techniques (epidural clonidine, ketamine, neostigmine, lumbar catheters) to support the claim that epidural anesthesia "is not recommended for hysterectomy due to low benefit:risk ratio." The issue of how to administer the anesthetic should not be decided by referring to a table or a Web site that refers to unusual techniques and then lumping a vast spectrum of operations under a single category designated "hysterectomy."

The article also states that epidural anesthesia is "clearly not appropriate for nephrectomy."¹ There is no reference for this statement, and the cited Web site has no information on nephrectomy. One might think that some modalities of an-

esthetic management, such as epidural anesthesia, might be "transferable" into "nephrectomy" from other procedures, similar to what is suggested for the use of gabapentanoids.

We do not "give an anesthetic for a nephrectomy." Rather we "give an anesthetic to a patient who is having a nephrectomy." This patient almost always has unique fears and apprehensions that often relate to pain on emergence and/or nausea and vomiting.⁸⁻¹¹ If, for example, a patient states that they are intolerant of "pain medicines, like Vicodin[®] or morphine" because of unpleasant side effects, such as nausea and vomiting or mental status changes, then it would seem appropriate to suggest that the anesthetic could be conducted without these drugs by using an epidural and an infusion of a drug that has antiemetic properties. Another patient scheduled for nephrectomy might fear the experience of severe pain upon awakening from anesthesia. An epidural titrated to cover the surgical wound site¹² would essentially guarantee a pain-free emergence that could be accomplished without the (use of and) side effects of opioids. Of course, the patient might also not want to have "a needle in their back"; ideally, all of these issues relating to anesthesia would be thoroughly discussed with the patient during the preoperative interview.

The idea of procedure-based pain therapy (PROSPECT) is reasonable, but the procedure itself may not always be the main factor in deciding how to administer the anesthetic or how to provide for postoperative pain therapy. Other important factors are the skills of the anesthesia provider, the concerns of the patient, and the experience and cooperation of nursing and surgical colleagues.

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(Accepted for publication April 22, 2010.)

In Reply:

We thank for Drs. Stites-Hallett and Larson for their comments regarding our article on postoperative pain management.¹ First, we agree that there are different types of hysterectomy (*e.g.*, open abdominal, radical abdominal, laparoscopic-assisted vaginal, and simple vaginal) and nephrectomy procedures. Unfortunately, our discussion on nephrectomy left out the word "laparoscopic." An open nephrectomy will have the same problems as an open colonic resection, where postoperative epidural analgesia is in fact evidence-based. According to the PROSPECT Web site,* the group has concluded, on the basis of the available literature on single modality analgesic interventions for hysterectomy procedures, that in low-risk patients, postoperative epidural analgesia is not cost-beneficial compared with simply

* <http://www.postoppain.org>. Accessed August 12, 2009.

using systemic multimodal nonopioid analgesics. However, it may be considered in high-risk patients. Drs. Stites-Hallett and Larson quote many earlier studies on the metabolic benefits of postoperative epidural analgesia; at the time they were published, they were important. However, with modern fast-track methodology,² the hospital stay has been minimized, and recovery no longer requires continuous epidural analgesia after hysterectomy procedures. It is true that there are some obvious benefits from intraoperative epidural analgesia with respect to pain control and prevention of postoperative nausea and vomiting in the *early* recovery period. Yet the use of effective multimodal nonopioid analgesia from the time the patient emerges from anesthesia has obviated the need for more invasive analgesic techniques such as epidural analgesia. For more extensive hysterectomies in high-risk patients, a different approach may be appropriate. However, the intention of our article was to give our view based upon the most recent literature. As with practice guidelines, well-argued considerations can justify deviation from these very broad recommendations in specific situations.

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(Accepted for publication April 22, 2010.)