

lents, as stated in the manuscript. As expected, after major and painful surgery, patients in both study groups are using more pain medicine at 6 weeks as compared with baseline. We would consider a steady decrement in opiate consumption per hour to represent an expected recovery process. Note again the 3- or 4-fold difference in opiate consumption between control and treatment groups at 6 weeks.

Dr. Seigne also wondered whether the statistical significance reached between the treatment and control groups in terms of the number of levels of surgery might have clinical relevance. We do not consider this factor to be clinically significant. We direct readers' attention to equal surgical times and blood loss.

In terms of Dr. Seigne's questions regarding longer term follow-up, this study was planned as the beginning to further studies. If we did further follow-up, we would either get the same results (better recovery in the treatment group) or there would be no difference at, say, 1 yr. At some point, we expect the latter to appear, which identifies the key question for any follow-up study, namely: What is the most relevant outcome parameter to measure in this type of study? Patient satisfaction? Functional activity level?

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(Accepted for publication January 5, 2011.)

Simple Math or Aberrant Physiology: The Complex Question of Modified Metabolic Syndrome

To the Editor:

I congratulate Glance *et al.*¹ for their work on elucidating the risk profiles of patients with modified metabolic syndrome. Their findings may change the way physician, billing, and insurance groups look at obese patients in the future. For this study, and for the interesting study methods, they must be commended. In addition, the described "complex" of obesity, diabetes mellitus, and hypertension encapsulates metabolic risk features of obstructive sleep apnea. The Perioperative Sleep Apnea Prediction score is a validated screening method that uses all three variables as a clinical prediction tool for sleep apnea.² Thus, the study findings could well be used to describe the perioperative outcomes associated with increased risk of sleep apnea.

One unresolved issue is whether diabetes and hypertension, two independent predictors of adverse outcome in previous outcomes studies,³⁻⁶ unfairly skewed the analysis. Discounting the supermorbidly obese patient population, obesity has been protective for morbidity in several studies, as duly noted by the authors. On the other hand, diabetes and hypertension have both been independent predictors of organ failure and mortality. Therefore, did the current study prove the increased risk of modified metabolic syndrome or simply prove that the preoperative presence of two independent risk factors (and one protective factor) is more significant than having one protective factor? Separating these two independent risk factors from obesity is important to determine whether the described effect sizes are independent of body mass index. Although the lack of these data in no way invalidates the study results in terms of identifying higher-risk profiles of obesity, if obesity was indeed protective, as is suggested in the literature, were patients with diabetes and hypertension but no obesity at greater risk of adverse outcomes? If so, are we truly using our risk assessment tools appropriately? These are yet unresolved questions; however, Glance *et al.*¹ have provided the initial spark that could ultimately cast light on them.

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(Accepted for publication January 25, 2011.)