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In Reply:

We thank Drs. Palte and Gayer for their thoughtful response to our recently published article.¹ We appreciate their input and would like to respond to their comments.

Patient's safety in anesthesiology is a critical point and becomes even more important in the context of medical research. We totally agree that ocular sonography can be detrimental by either thermal or mechanical injuries. Palte *et al.*,² in an animal study on four rabbits, have clearly demonstrated that significant increase in ocular temperature (more than 1.5°C) may occur in subcutaneous, corneal, cameral, or vitreal areas after 90 s of direct application to the cornea of a Micromaxx® 10 MHz probe (Sonosite, Bothell, WA); the latter been used in our study. They have also shown that this thermal effect is time dependent. In our study, two trained investigators made all measurements, and strict attention was paid to decrease exposure time to ultrasound to less than 60 s. As has recently been highlighted,³ "minimizing the exposure time is probably the most important factor for ensuring patient safety from thermal injury." Moreover, in our study, applying the probe on a thick layer of ultrasound gel over the closed upper eyelid could have decreased the heat transfer.

Anesthesiologists who want to train for ocular ultrasonography should, however, be aware of the risk of prolonged exposure to ultrasounds. In the view of current knowledge in the topic, limiting the examination time to less than 90 s seems to be safe. It would be of great interest to develop ocular phantoms modelizing the eye and optic nerve sheath to allow training in ocular ultrasound without unnecessary human exposure to ultrasound. We also strongly encourage manufacturers to develop specific ocular settings or dedicated probes for ocular ultrasonography with low power output and mechanical and thermal indexes less than 1, allowing nonspecialists in ocular sonography to study in full safety the incidence of raised intracranial pressure in pathologies as preeclampsia or others.

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Updated Pain Guidelines: What Is New?

Recently, the American Society of Anesthesiologists Task Force on Acute Pain Management published an "updated report and practice guidelines for acute pain management in the perioperative setting."¹ Although this is a laudable effort and the Task Force committee includes anesthesiologists with established expertise in the topic, I must admit as a surgeon with an interest in analgesia and postoperative recovery that I have several concerns on the overall message of the practice guidelines. First, it is claimed that the present guidelines differ from existing guidelines by providing "new evidence in an updated evaluation of scientific literature," but a closer look at the reference material including almost 250 references shows less than 10 references from 2009 and upward. Many publications on single analgesic interventions as well as multimodal techniques have been published in the last 3 yr, which may change their conclusions if updated. For instance, by several meta-analyses or reviews on interventions like preventive analgesia, paravertebral blocks in pulmonary surgery, epidural analgesia in laparoscopic colonic surgery, local infiltration analgesia *versus* spinal analgesia in hernia surgery, and high-volume infiltration analgesia in major lower-limb arthroplasty *versus* peripheral blockades as well as the many efforts to provide improved analgesia and/or opioid-sparing by a combination of nonopioid analgesics. Importantly, many publications from the PROSPECT Collaboration Group have provided procedure-specific recommendations for perioperative acute pain management—which was not discussed in the present guidelines. This may be clinically important, because it has become evident that choice of analgesia is highly dependent on the specific surgical procedure regarding analgesic efficacy, potential side effects, and effects on recovery.