the authors' dose-effect analysis of nitrous oxide on PONV is very clinically relevant, although not emphasized in the abstract or report. The authors note in the report that nitrous oxide, when used for less than 2 h, did not seem to result in added PONV compared with the non-nitrous arm. This observation is congruent with existing literature,[6] is a randomized comparison that carries with it the methodologic robustness of the original ENIGMA II trial, and has applicability in a wide variety of clinical settings. In closing, we thank the authors for their thorough reanalysis and presentation of the ENIGMA II data for the PONV outcome. This secondary analysis is revealing, but the conclusion that prophylaxis nearly eliminates PONV seems untenable.

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Competing Interests

The authors declare no competing interests.

Edmond C. K. Li, M.D., Lloyd D. Balbuena, Ph.D., Jonathan J. Gamble, M.D. University of Saskatchewan, Saskatoon, Canada (E.C.K.L.). edmond.li@usask.ca

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In Reply:

We thank Li *et al.* for these perspectives. We agree that nonrandomized studies have greater risk of bias and confounding, and the results may therefore be misleading. This certainly applies to studies using propensity-based methods. We would first like to point out that in their letter Li *et al.* state we used propensity score matching. In fact, we actually used inverse probability of treatment weighting. These are distinct methods (although both based on propensity scores) and estimate different quantities (effect of treatment overall *vs.* effect of treatment in the treated).

Table 1. The Incidence (%) and Relative Risk of Postoperative Nausea and Vomiting in Patients Receiving Nitrous Oxide for Major Surgery in the ENIGMA II Trial[1]

	Nitrous Oxide (n = 3,483)	No Nitrous Oxide (n = 3,509)	Relative Risk (95% CI)	*P* Value
Overall	14.5%	10.8%	1.35 (1.19–1.53)	<0.001
Antiemetic prophylaxis				
No	16.6%	9.6%	1.75 (1.43–2.13)	<0.001
Yes	13.1%	11.7%	1.12 (0.95–1.32)	0.18

The risk estimate differed according to use of antiemetic prophylaxis; interaction *P* value 0.001.

ENIGMA II = Evaluation of Nitrous Oxide in the Gas Mixture for Anesthesia II.

More importantly however, our comments regarding the risk mitigation associated with antiemetic prophylaxis in patients exposed to nitrous oxide were based not on the secondary analysis referred to by Li *et al.* but in a preplanned secondary analysis of the original large randomized trial.[1] Relevant, expanded details are provided in table 1. The emetogenic effect of nitrous oxide was less apparent in those who received prophylactic antiemetics before the end of surgery compared with those who did not. The interaction *P* value was 0.001, indicating that there was a statistically significant differential effect between these two subgroups. We acknowledge that use of antiemetic prophylaxis was left to the discretion of the attending anesthesiologist, but such use was more likely in those with more risk factors for postoperative nausea and vomiting (PONV; as we reported in our publication).[2] That is, there was a selection bias, but it would underestimate the protective effect of antiemetic prophylaxis because such use was higher in those with greater risk of PONV. We therefore stand by our conclusion that PONV prophylaxis near-eliminates the risk of nitrous oxide-induced severe PONV after major surgery.

Competing Interests

The authors declare no competing interests.

Paul S. Myles, D.Sc., F.A.N.Z.C.A., Jessica Kasza, B.Sc., Ph.D. Monash University, Melbourne, Australia (P.S.M.). p.myles@alfred.org.au

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Promoting Sustainable Practices *via* Art

To the Editor:

A few plastic caps from medication vials used for an individual anesthetic may seem insignificant; however, these items accumulate. Using five vials per case for 30,000 cases annually, we waste 150,000 caps per year. At the University of Wisconsin–Madison, we identified an opportunity to divert this commonly discarded material from landfills. Although too small for comingled recycling, caps can be recycled successfully when collected separately. Recycling rates of 20 to 25% are achievable in the operating room without compromising infection control or creating financial constraints.[1]

Forming a multidisciplinary green team is an effective means for promoting sustainable practices.[2,3] To raise provider awareness of the amount of waste that can be generated in a healthcare setting, our green team initiated a vial cap collection (fig. 1). In addition to recycling caps, we collaborated with our hospital art coordinator to create mosaic artwork from this colorful material (fig. 2). Interest in the art project was greater than anticipated, creating dialogue between staff in all areas of the hospital. Staff have joined together for several art-making events in which participants sort the caps by color and participate in gluing the caps to a large art piece. Educational information about green efforts in the healthcare setting was on display for participants to learn more. Seeing the large collection of small plastics conveys the impact of medical waste. Holding these plastics in their hands to create artwork inspires healthcare providers to look at the bigger picture of the environmental impact of our practice.

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Competing Interests

Dr. Zuegge receives nonclinical time for her role as Medical Director of Sustainability for University of Wisconsin Health. The Department of Planning, Design, and Construction funded the printing, materials, and supplies for, and framing of, the artwork. The other authors declare no competing interests.

Karin L. Zuegge, M.D., Meghan E. Warren, D.O., Bridget L. Muldowney, M.D., Amanda T. B. Kron, B.S. University of Wisconsin School of Medicine and Public Health, Madison, Wisconsin (K.L.Z.). zuegge@wisc.edu

Fig. 2. One of the completed artworks now on display in our hospital.