the ASA score is related to its simplicity. The ASA score has penetrated beyond anesthesia and even beyond human medicine.[4] It may even be considered on a par with the Apgar score.[5]

We hesitate to support the authors' recommendation to use the examples to the ASA score, instead of using common sense and simple rules. Having a list of examples transforms a simple albeit subjective universal score into a cumbersome one. Keep it simple, stupid (KISS).[6]

Competing Interests

The authors declare no competing interests.

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In Reply:

I thank Drs. Avidan and Weiniger for their comments on my article.[1] Their suggestion and use of the acronym KISS (keep it simple stupid) summarizes the point of my editorial much more succinctly than my two pages. I could not agree more with them that adding nonvalidated examples to a simple, "commonsense" categorization may hobble the time-honored utility and universal use of the American Society of Anesthesiologists (ASA) Physical Status Classification System. I smiled when I saw the veterinary reference in their letter. I had originally referenced a study using the ASA classification in veterinary anesthesia but removed it due to space constraints.[2] Anesthesiologists need to be extremely cautious before altering a tool as far-reaching and surprisingly robust as the ASA classification in the practice of medicine, even across genera.

Competing Interests

The author declares no competing interests.

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In Reply:

We thank Drs. Avidan and Weiniger for their comments related to our article, "Adding Examples to the ASA-Physical Status Classification Improves Correct Assignment to Patients."[1] They posit that the addition of objective examples to the previously subjective American Society of Anesthesiologists Physical Status (ASA-PS) Classification System may hinder the universal application of the ASA-PS score by unnecessarily increasing the complexity of the system.

As stated in their letter, "the ASA score has penetrated beyond anesthesia." It is our belief that this is exactly why the examples *should* be used. With the increasing use of the ASA-PS score by nonanesthesia providers, there are many assigning ASA-PS who do not have the anesthesia-related training to understand the differences between classifications. Although we agree that physician anesthesiologists currently use "common sense" in determining the ASA-PS, the gestalt that many of us have in applying the ASA-PS in practice may not exist for those who do not have experience in anesthesiology. Additionally, poor interrater reliability for the ASA-PS has been shown repeatedly.[2–4] For these reasons, the ASA-PS examples may ultimately prove more useful for nonanesthesia providers than anesthesia ones. As we demonstrated, with examples there was improvement in correct assignment for anesthesia and nonanesthesia providers with no significant difference in the rate of correct assignment between anesthesia-trained and nonanesthesia clinicians.[1] We reiterate that the examples are guidelines and recognize the list is not comprehensive; the examples should provide a framework indicating the most likely appropriate ASA-PS score for commonly encountered diseases. The final determination of ASA-PS should be made by a physician anesthesiologist. We recognize that until further studies are done, the true effect of these examples in clinical practice is yet to be seen. We agree that uniform application across the board, even with examples, is unlikely, but given the inconsistency that already exists with ASA-PS score assignments, it is hard to argue that an addition with the potential to improve objective scoring should not be used clinically.

Competing Interests

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Use of Vasopressin in Vasoplegic Syndrome with Reduced Ejection Fraction: Asking for Trouble

To the Editor:

I read the article by Hajjar *et al.* with great enthusiasm.[1] First, I would like to congratulate the authors for their ambitious study and reasonable conclusions. They concluded that vasopressin improved clinical outcomes better than norepinephrine in vasoplegic shock after cardiac surgery. I would like to discuss the concerns associated with the use of a pure vasoconstrictor after cardiac surgery.

Transient or sustained vasoplegia is not uncommon after cardiac surgery and it is characterized by a fall in systemic vascular resistance (SVR).[2] In addition, myocardial stunning or hibernation after cardiac surgery commonly results in reduction of left ventricular ejection fraction.[3] Furthermore, preoperative low ejection fraction is one of the most documented predictors for vasoplegia after on-pump cardiac surgery.[2] A reduction in SVR may be associated with improvement in cardiac index.[4] To maintain systemic blood pressure solely by increasing SVR without augmenting cardiac contractility may prove counterproductive.[5] Therefore, our target should be to maintain SVR within normal limits.[6] Although the authors mentioned that the cardiac index did not change after vasopressor infusion, in patients with reduced ejection fraction, cardiac index expectedly reduces after pure vasoconstrictor infusion.[7] Vasopressin-related myocardial dysfunction does not arise as a result of increase in SVR, but from a direct effect on cardiac contractility.[8] In the current study, the majority of patients (53%) had a normal preoperative ejection fraction (greater than 60%). Unlike vasopressin, its receptor antagonist has shown to improve left ventricular systolic function.[9,10] An assessment of ejection fraction in vasoplegic syndrome would have been ideal for better interpretation of the results of this study. In patients with preserved ejection fraction, vasopressin may prove superior to norepinephrine, but generalization of this study finding in patients with vasoplegic syndrome and diminished ejection fraction could be debatable.

Competing Interests

The author declares no competing interests.

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