receive any postoperative analgesia. No shoulder tip pain was observed in any of the patients.

Case 5 had a laparoscopic hernia repair under general anaesthesia. A left-sided unilateral TAP block was performed as detailed above. Surgical time was 140 min. The prescribed postoperative pain relief consisted of i.m. morphine, oral acetaminophen, and diclofenac as required. No opioids were needed in the immediate postoperative period. The patient was considered to be fit for discharge 24 h after surgery.

The TAP block has been found to be an effective method of providing postoperative analgesia in patients undergoing midline abdominal wall incision.1 Until now, the use of ultrasound-guided bilateral TAP blocks for laparoscopic surgery has not been tested. Our cases have shown that TAP blocks provide effective pain relief both intraoperatively and for several hours into the postoperative period after laparoscopic surgery. The use of TAP blocks reduced the need for intraoperative and postoperative opioids and the side-effects associated with their use. None of our patients was drowsy or required antiemetics in the postoperative period. Hence the technique is suitable for day-case laparoscopic surgery. The absence of shoulder tip pain has been a finding in all cases.

We suggest that TAP blocks can be incorporated as part of the analgesia regimen for day-case laparoscopic surgery. TAP blocks under ultrasound guidance are easy to perform, provide consistent analgesia, and have displayed a good safety profile.

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Pregabalin for acute pain management: a shift in paradigm

Editor—We would like to commend the authors for this interesting and intriguing use of pregabalin for perioperative pain relief.1 The use of pregabalin in the management of acute pain control after surgery has been attempted for a significant period of time. Although pregabalin may prevent central sensitization and potentially reduce chronic pain, its use in the acute setting is gaining greater importance particularly when referring to multimodal analgesic techniques. Although this paper refers to the use of a higher dose of pregabalin (150 mg), there is no concerted effort to maximize the pain control using regional techniques in the operative and perioperative phases. This, in addition, may have provided a longer duration of pain relief. We are also curious to see if the authors contacted these patients after 2 weeks to see if there was any residual pain. If this is the case, then the addition of pregabalin to preoperative premedication may very well be the ‘gold standard’ for managing pain.

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Editor—we thank Drs Siddiqui and Suresh for their comments on the use of preoperative single-dose pregabalin for attenuation of acute postoperative pain.1 Pain is a multi-factorial phenomenon and combinations of analgesics acting at different sites are advised. Thus, with synthetic variants of analgesic agents being developed, there is opportunity for innovation. The present study was conducted with this basic aim.

We would like to address some other concerns raised. We did not use any regional anaesthesia techniques in the present study because all the patients included in the study received i.v. fentanyl by a patient-controlled analgesia device. Secondly, our study concluded 24 h after operation and therefore we did not evaluate our patients thereafter. Evaluation at a later stage for residual pain, if any, certainly is an interesting idea and further clinical trials can be designed in this direction.

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Perioperative management of a patient with maple syrup urine disease

Editor—Maple syrup urine disease (MSUD) is an autosomal recessive metabolic disorder caused by a deficit of oxidative decarboxylation of branched-chain amino acids.