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Reply from the authors

Editor—We read the letter by Dr Park and we were very pleased by his friendly words. We are also pleasantly surprised by a postoperative nausea and vomiting (PONV) incidence of 34% in high-risk patients. It would be interesting to know more about the definition of a ‘high-risk patient’ in that study. Dr Park describes a situation in which postoperative opioid patient-controlled analgesia (PCA) is used as the only risk factor triggering PONV prophylaxis. Since postoperative opioid use is indeed an important risk factor for PONV, it correctly triggers prophylaxis. There is, however, room for improvement in estimating PONV risk based on the other known risk factors or even better: using a risk score. According to Dr Park’s description, there is currently no guideline for PONV prophylaxis in Korea, so a possible reason for this insufficient risk estimation might be that some of our Korean colleagues are not aware that there are PONV risk factors other than postoperative opioid use. Workload and lack of manpower, as mentioned by Dr Park, are also well-known reasons for non-adherence to guidelines. If a guideline for PONV management would be implemented in Korea, adherence to this guideline could possibly be improved using a decision support system (DSS). When designing a DSS, however, one should carefully consider the properties required to facilitate success. These were well described in a review and include (among others) automatic appearance of reminders, specific advice, and integration in an electronic medical record.1

The guideline described in our article was the departmental guideline as it was at the time of data collection.2 This evidence-based guideline was based on research with regard to optimal risk estimation, and also optimal medication prophylaxis.3 4 Other possible interventions, such as total i.v. anaesthesia, locoregional anaesthesia if possible, and metoclopramide, were not mentioned in the article but were incorporated in the guideline. This guideline was implemented after a consensus process and we feel that it is a practical and applicable one. There are other options as well though. For example, in another hospital, we agreed to add one prophylactic intervention for each positive risk factor. We feel that it is important to weigh all known risk factors and prophylactic options and decide which ones to use in which preferential order using a consensus process. As a guide for that process, comprehensive guidelines of PONV management are available. The most extensive being the SAMBA guideline.5

In summary, we think that it is an excellent initiative to develop a Korean guideline for the management of PONV and wish Dr Park wisdom and success in doing so. Once the guideline has been developed and implemented, it is even better to use automated reminders in supporting it.

Declaration of interest

None declared.

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Goal-directed therapy: each therapeutic regimen needs its indication

Editor—We read with great interest the article by Brandstrup and colleagues5 providing interesting data on a multi-centre study on goal-directed fluid therapy (GDT) vs a zero-balance regimen in patients undergoing colorectal surgery. During the last decades, numerous single-centre studies, the majority performed with oesophageal Doppler-guided treatment strategies, demonstrated a positive effect of GDT on length of hospital stay, patient morbidity, and mortality.2–4 In contrast to these studies, Brandstrup and colleagues found no significant difference in length of hospital stay or patient outcome. However, when looking in detail on the design of the study, these results are not very surprising, owing to two aspects: although patients with a preoperative risk score of up to ASA III were eligible for this study, 79% of patients were classified ASA I or II in the zero-balance group, and even 89% in the Doppler group. By definition, ASA I and II