as having this complication depended upon the method of measurement. What was particularly striking was that there was no overlap between the groups defined by the two different methods. Hence, we do not know what our incidence of clinically important PONV is, should we use VAS75, PONVIS or both? Whatever the incidence, it occurs against the background of our best ever finding of 67% adherence to our PONV prophylaxis guidelines so, as we continue to audit this, it is important for us to have a reproducible method of measuring the incidence of severe PONV. Myles, Wengritzky and co-workers have made useful and important contributions to defining the severity of PONV. In clinical practice, we are never going to be able to eliminate PONV entirely and a more realistic hope will be to reduce the severity, such that the number of patients suffering enough to impair their recovery is minimized. We do however need to be able to capture these patients accurately, reliably, and reproducibly. Translating their findings to our in-patient population indicates that this important goal has not yet been reached.

**Declaration of interest**

None declared.

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2 Myles PS, Wengritzky R. Simplified postoperative nausea and vomiting impact scale for audit and post-discharge review. *Br J Anaesth* 2012; 108: 423–9

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**Reply from the authors**

Editor—We thank Dr Brampton and colleagues for their interest in our studies and applaud the Aberdeen Royal Infirmary (ARI) anaesthetic department’s audit practices. The most compelling observation of this audit was the moderately high incidence of any postoperative nausea and vomiting (PONV), but only a small proportion of this could be rated as clinically important. That is, most episodes of PONV are mild and often transient in nature. This reality can be likened to the presence of pain after ambulatory surgery, with most of it being well controlled and only of mild intensity. Why should we aim to eliminate PONV entirely, when it seems to not be a clinical problem for the majority of patients?

With respect to the different results obtained when using our two different PONV severity scales, we would recommend the 2012 version because our own experience was that the former scale was ambiguous for some clinicians and a sizeable proportion of patients. As outlined in our second publication,

we chose to revise the PONV severity scale because of this ambiguity—we thus recommend the revised, simplified scale for future use. The validation cohort used in our original study included patients undergoing day stay and minor surgery.²

**Declaration of interest**

None declared.

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1 Myles PS, Wengritzky R. Simplified postoperative nausea and vomiting impact scale for audit and post-discharge review. *Br J Anaesth* 2012; 108: 423–9


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**Effects of an intraoperative infusion of 4% succinylated gelatine (Gelofusine) and 6% hydroxyethyl starch (Voluven) on blood volume**

Editor—We read with interest the article comparing 4% succinylated gelatine and 6% hydroxyethyl starch (HES) and its findings that 6% HES produced a statistically significant greater increase in serum chloride concentration suggesting a tendency to produce hyperchloraemic acidosis in comparison with 4% succinylated gelatine, while the blood-volume expanding effects were not significantly different.¹

The type of colloid used in the resuscitation of critically ill patients has been debated by clinicians for many years. However, the European Society of Intensive Care Medicine (ESICM) Task Force have advised in March 2012 against the use of HES in patients with severe sepsis or risk of acute kidney injury.² Furthermore, the Scandinavian Starch for Severe Sepsis/Septic Shock Trial (6S) has shown there to be an increased 90 day mortality and increased risk of acute kidney injury requiring renal replacement therapy with 6% HES,³ and thus, we feel together with the results of the published article, there is now strong evidence to suggest we should not be using HES in critically ill patients.

Recently, the use of any colloid in the resuscitation of critically ill patients has been questioned, with a Cochrane Systematic Review concluding that there is currently no evidence from randomized control trials that shows a survival advantage with colloids of any kind vs crystalloids.⁴

In this time of debate over colloid use, we are however receiving increasing promotion of balanced gelatines, for example, isoplex, a 4% succinylated gelatine solution for infusion...