Correspondence

Postoperative pain management and acute pain service in Canada

To the Editor:

Zimmermann and Stewart gave a very interesting survey of the development of acute pain services in Canada.¹ We agree with most of their recommendations for pain therapy on normal wards and their reservations held against the use of epidural opioid analgesia (EOA) especially. Unfortunately, the authors quoted our German questionnaire survey² wrongly, i.e., supporting the use of EOA on normal wards. On the contrary, this survey summarized more than 100 cases of severe respiratory depression in 25% of all departments questioned. This was the most frequent potential life-threatening side effect in this survey. Therefore, in accordance with most Canadian anaesthetists, we concluded that the use of EOA may not be recommended outside of ICU or the recovery room unless very close monitoring of respiration and vigilance is guaranteed. The main argument is the delayed onset of respiratory depression (in contrast to immediate occurrence of hypotension following epidural local anaesthetics). Even the protagonists of EOA on normal wards³ recommend a respiratory monitor and ICU observations for the first 48 hr for all patients with increased risk (e.g., age > 50 yr, ASA status > II, thoracic or upper abdominal surgery). These criteria hold true for most of our patients where epidural analgesia was used.⁴ Under these circumstances the continuous infusion of low-dose bupivacaine seems to be a safer alternative, provided that visits to these patients (including neurological examinations) are made by an acute pain service at least once a day.^{4,5}

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- 4 Maier C, Kibbel K, Mercker S, Wulf H. Postoperative Schmerztherapie auf Allgemeinen Krankenpflegestationen - Analyse der achtjährigen Tätigkeit eines Anästhesiologischen Akut-Schmerzdienstes [Postoperative Pain Management on Surgical Wards - Eight Year's Experience of an Anesthesiology-based Acute Pain Service]. *Anästhesist* 1994 (in press).
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REPLY

Thank you for the opportunity to respond to the concerns of Drs. Maier and Wulf. Their paper¹ was published in German and we based our comments on a Medline English abstract which stated "EA was administered in 62.4% on ordinary wards" and "... 66.7% also favoured epidural opioids on ordinary wards." We interpreted these percentages to indicate the majority of those surveyed supported the use of epidural opiates on ordinary wards; however, if we have misrepresented their results we apologize.

We agree that respiratory depression is a major concern when administering epidural opioid analgesia. However, Ready does not recommend "... ICU observation for the first 48 hours for all patients with increased risk," but rather "... admission to ICU should be based on customary criteria such as medical status and the type and duration of surgery."² In subsequent reports he confirms that adjustment of epidural morphine doses in combination with simple serial assessment of the level of consciousness allows for the safe administration of epidural opioids on regular hospital wards, even for those patients with advanced age and poor physical condition.^{3,4} This is the approach we have taken at our hospital and we have not had a single major adverse event that can be attributed to the use of epidural opioids on general surgical wards. We agree with Baxter⁵ that the risk of respiratory depression with postoperative opioids is the same regardless of the route they are administered.

Finally we disagree with the statement of Drs. Maier and Wulf that continuous epidural infusion of low-dose bupivacaine is a safer alternative than epidural opioids. Epidural local anaesthetics, even in low doses, have the potential to produce sympathetic, sensory, and motor blockade as well as cumulative