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PONV in Outpatients: when should it be assessed?

To the Editor:

Despite major advances in anesthesia, postoperative nausea and vomiting (PONV) still remains a common distressing problem facing patients. In ambulatory care setting, it may lead to delayed discharge and unanticipated overnight admission, both with financial implications to both the patient and the health provider. Referring to the recent article by Dr Chung in the April edition of this journal, I would like to comment on the low incidence of PONV (2.18%) reported in patients undergoing ambulatory surgery in this centre.

In a recent study of 140 patients undergoing dental extractions under general anesthesia (propofol/N₂O/sevoflurane) in our ambulatory care unit, we noted a similarly low incidence of PONV (2.9%) in the post anesthesia room (PAR). However, the incidence at 48 hr post-op was 28%. Could the author provide further details on the incidence of PONV at 48 hr at the Toronto hospital to allow inter institutional comparison?

Documentation of other adverse events (e.g. respiratory, CNS, cardiovascular, excessive pain and bleeding) in the PAR can be accurate assessors of surgical day care associated morbidity. However, in the case of PONV, perhaps follow-up by telephone may provide us with more realistic information?

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REPLY:

We thank Dr. Collins for her interest in our article.¹ Overall, 4.6% of the patients developed PONV before dis-

charge. We interviewed 30% of the patients 24 hr postoperatively and found that 9.1% of the interviewed patients suffered from PONV in the first 24 hr. We do not have data on the incidence of PONV 48 hr postoperatively. Detailed information on PONV in the same patient population were presented elsewhere.²

Determining the PONV incidence 24 or 48 hr postoperatively may provide more realistic information on total PONV than recording in-hospital PONV occurrences. Most outpatients tend to assume normal activities in the first 24 hr after surgery, which may contribute to PONV following discharge. Total PONV incidence, including the occurrence of post-discharge PONV, more appropriately reflects the long-term impact of ambulatory surgery on patients, while in-hospital PONV incidence may be more important in determining PACU cost or PACU nursing workload. In our study, we decided to follow up after the first 24 hr. We expect the highest PONV incidence to occur during the first 24 hr postoperatively as residual anesthetic effect subsides with time. With a 9.1% PONV incidence at 24 hr, it is unlikely that the 48-hr PONV incidence in our institute would be close to the 28% PONV incidence in Dr. Collins' institution. The case-mix of ambulatory population in our institution, 36% underwent relatively low-risk eye surgery, may explain the difference. Undoubtedly, characteristics of the patient populations play a key role in any interinstitutional comparison.

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Continuous interscalene block

To the Editor:

We read the article "A new technique of continuous interscalene nerve block"¹ and the accompanying editorial² published in the Canadian Journal of Anesthesia. We approve of the suggestions made by Coleman and Chan² to prevent damage to the catheter by the sharp end of the Tuohy needle and the recommendations not to perform interscalene block