Letter to the Editor in Response to: The Correlation Between Prolonged Corrected QT Interval with the Frequency of Respiratory Arrest, Endotracheal Intubation, and Mortality in Acute Methadone Overdose

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To the editor,

We read with interest Farsi et al. [1] recent publication investigating QTc interval as a predictor of death, respiratory failure, and endotracheal intubation in methadone overdose. We appreciate the rigor with which this study was performed; however, in our practice, we have found that a depressed respiratory rate ($<10/\text{min}$) is better associated with the need for naloxone administration [2]. There is also a known correlation with prolonged QTc and methadone use [3]. Since there is an association between QTc and torsade de pointes (TdP), we would like to see telemetry findings of the patients, particularly the patients who required intubation, to determine how many patients had TdP as the etiology of their arrest.

Another point to be raised that may be related to regional practice differences is that the proportion of patients requiring intubation from methadone overdose seemed inordinately high. We wonder if naloxone was used in attempt to reverse the overdose at all, which was not reported in the article. Given that the majority deaths were from complications of intubation such as pneumosepsis, avoidance of endotracheal intubation may have improved survival in this patient population.

As the authors indicate, it indeed was a great hypothesis-generating study using QTc duration as an independent predictor of mortality in methadone overdose. It would be interesting to see patients who have EKGs performed at their outpatient methadone clinic to determine if there is a long-term mortality association with QTc duration. If so, prolonged QTc duration could be a good indicator that patients should be switched from methadone to another therapy such as buprenorphine.

References

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