

is predictable and indeed inevitable, and that is pure self-deception on the anaesthetist's part to imagine that patients will not experience it if a "wait and see" approach is adopted with respect to the use of analgesics. The consequence of this is that the onus is shifted from the patient (who until now has had to declare his pain to his hospital attendants in order to receive acknowledgment and treatment for it) to the physician, who should now be taking all possible steps to prevent that pain from occurring in the first place. Although Dr. Moote referred to the interaction between nurse and patient in determining exactly how the anaesthetist's prescription is interpreted, she made no mention of the rôle played by the surgical resident in the management of postoperative pain. In the United Kingdom, although the anaesthetist usually writes the prescription for postoperative pain relief, if the regimen is inadequate or not to the nurses' liking, it is the house officer who is consulted about the problem, and the responsibility for managing the patient's pain is shifted yet again. This newly qualified doctor is expected to be knowledgeable in such matters, but has probably received little formal training in this important topic. Once more, the relief of postoperative pain has become "someone else's problem."

A recent English study² used a questionnaire to assess the knowledge of newly qualified house officers about the management of postoperative pain, and found that many of their responses were inappropriate, if not somewhat hazardous. We have seen for ourselves how effective such simple measures as writing up oral analgesics regularly instead of "as required" can be. We have learned how widely opioid requirements vary by seeing how our patients use their PCA machines, just as they have benefited from being able to tailor the analgesic to their pain. Surely it is time to include doctors in training, who are still liberal and receptive, in this new, humanitarian revolution? And surely it is anaesthetists who should be leading the way?

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REPLY

I would like to thank Dr. Smith for his interest in my article on the prevention of postoperative pain. As stated by Dr. Smith, simple measures as oral analgesics given at regularly scheduled round-the-clock (not *prn.*, or as required), can profoundly improve the management of postoperative pain. Also, opioid requirements vary tremendously and we observe this daily in patients using PCA. Analgesic protocols must allow for variability in dosing schedules. This can be accomplished by providing a "rescue" dose of analgesia.

Another very important tool is a pain "flow sheet," which can be used to document the efficacy of the analgesic dose and any side effects or complications. In this manner, opioid analgesia may be titrated to patient's need while identifying side effects such as nausea or respiratory depression which require treatment. Finally, it is important to involve the patient in this process to give the patient control of their analgesia, whether or not they have a pump at their bedside, or a button in their hand. Patients, nurses and physicians must learn to talk openly about pain and use common language such as verbal rating scales or visual analogue scores. The flow sheet is used to document these pain scores, in addition to analgesic agents and side effects. This bedside information is essential to monitor and mold the analgesic regimen to fit the individual needs of each patient.

Numerous guidelines for acute pain management agree that NSAIDs have a fundamental role to play in the management of acute postoperative pain. The paper by Gould¹ reveals a poor theoretical and practical knowledge of analgesic agents, where NSAIDs were often used inappropriately. While there has been much published on the use of NSAIDs for postoperative pain, the appropriate application of this knowledge in routine clinical practice has been slow and sporadic.

I agree that knowledge regarding pain management is inadequate and that more education is essential. In Canada, the management of both acute and chronic pain is an integral and required component of the residency training programme for anaesthesia. Changing attitudes about pain is an extremely important element of undergraduate medical education and may have an important impact on future practice patterns.² Anaesthetists have much to offer medical schools in providing these programmes. The International Association for the Study of Pain has developed such a curriculum for pain management.³ The issue of medical education and pain management has been addressed repeatedly in the literature, but the haunting question remains: "Is education enough?"^{4,5} Perhaps education alone is not enough, since a recent editorial calls for national initiatives to improve the management of patients in pain.⁶ This returns us to the root of the problem of inadequate analgesia which was so eloquently summarized by Bonica,⁷ "for nearly 30 years I have studied the reasons for inadequate management of postoperative pain, and they remain the same ... inadequate or improper application of available information and therapies is certainly the most important reason for inadequate postoperative pain relief."

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Does the laryngeal mask have a role outside the operating theatre?

To the Editor:

Devitt considers the LMA unsuitable as an emergency airway outside the OR.¹ His views are based in part on his study on positive-pressure ventilation with the LMA² and the belief that studies demonstrating the superiority of the LMA over the tracheal tube and facemask in a controlled experimental setting may not be applicable to the clinical circumstances of emergency airway management where patients are at risk of aspiration and often have pulmonary pathology. This is valid, as is Martens' suggestion that Utstein style outcome studies are required to prove the value of the LMA for cardiac arrest patients.¹ There is, however, prospective evidence from field studies and anecdotal evidence from case reports that the LMA has a role outside the operating room, albeit undefined.

Firstly, Grantham *et al.* trained 30 ambulance officers in the use of the LMA and 233 insertions were attempted in the field over a 12-month period.³ The LMA provided an effective airway in 90% of patients sufficiently comatose to compromise airway care and soiling occurred in ten patients. Secondly, a large multicentre trial found that after a training programme, ward nurses obtained satisfactory chest expansion with the LMA in 86% of cases during CPR.⁴ In 7% of these, subsequent intubation by an anaesthetist proved difficult, and ventilation was continued through the LMA. There was one case of aspiration and the interval between cardiac arrest and LMA insertion was 2.4 min. Thirdly, Kokkinis reported 49/50 successful LMA placements during in-hospital CPR

by junior anaesthetists with very good blood gas analyses for survivors and non-survivors and no instances of aspiration.⁵ Fourthly, LMA-trained neonatologists were able to resuscitate 21/21 neonates initially with the LMA and in all cases insertion was successful at the first attempt.⁶ Finally, two cases have been reported of its successful use in providing emergency airway control in trapped road traffic accident victims where access to the patient was limited in making laryngoscopy impossible⁷ and it has been used during emergency airway management in adult⁸ and neonatal ICU,⁹ and during interhospital helicopter transport of a neonate (De Maio, PC).

I feel that this constitutes reasonable evidence that the LMA has a role in emergency airway management outside theatre – a view shared by the Japanese Ministry of Health and Welfare, which approved the use of the LMA by paramedics during CPR in February 1992, and reiterated at the world's first symposium on the LMA in pre-hospital care held in Japan in May 1993. More recently, the United Kingdom Resuscitation Council has approved the training of "paramedical staff" in the use of the LMA and a United Kingdom-wide trial will shortly commence on its use in the field. Until the results of such trials are available, the role of the LMA in the emergency situation will remain unproven. Meanwhile I would suggest that Devitt and others¹⁰ keep an open mind and remember that in assessing the potential role of the LMA outside the operating theatre, the risks of a less secure airway must be balanced against the benefits of ease of training, possible wider availability than tracheal intubation, skills maintenance and speed of insertion.³ In addition, consideration must be given for those difficult airway situations where the facemask and tracheal tube fail to secure the airway.

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