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IN REPLY

In reply: Is 60 mg a suitable dosage for same-day spinal prilocaine?

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To the Editor,

We thank Dr. Manassero *et al.* for both their interest in our article and their comments.[1,2]

As discussed in our paper, we decided to perform spinal anesthesia with 60 mg of 2% hyperbaric prilocaine instead of 40 mg as suggested in the article by Camponovo *et al.*[3] because their report specified that 13% of patients had required additional intraoperative analgesia. A regional anesthesia regimen in which one patient in ten needs supplemental analgesia does not fulfill our clinical quality criteria and cannot be recommended as the standard of care. The achievement of a T10 level is not nearly as important as patient safety and comfort. Therefore, it is not surprising that use of only 40 mg of prilocaine would show a faster recovery, but as mentioned above, it has a failure rate of 13%.

We also discussed that it is difficult to compare discharge time as different discharge criteria were selected in different papers. Our criterion of bladder voiding prior to discharge is much more stringent than the criteria by Camponovo *et al.*—i.e., "resolution of motor block, defined as time to unassisted ambulation or Bromage's score = 0". The mean (SD) time to motor block resolution in the 40-mg group was 92 (36) min compared with 118 (37) min in the 60-mg group. Nevertheless, the mean (SD) time to void was 195 (60) min in the 40-mg group and 218 (56) min in the 60-mg group, which is comparable with our results. If we are going to offer ambulatory spinal anesthesia to all patients, including the elderly male population, we recommend including spontaneous voiding in the discharge criteria to avoid expensive unscheduled readmissions due to urinary retention.

The times measured for this study represent real life. We could have opted for measuring the time from spinal anesthesia until readiness for discharge, which would have meant that the clock would have been stopped once the patient achieved all the criteria for discharge. In real life, however, it is clear that, once the patient has achieved all discharge criteria, the discharge procedure starts (discharge instructions are handed out, a clinic visit is booked, a taxi is summoned, etc.). The goal of our study was to present an image depicting the clinical reality so that clinicians could determine the likely impact of introducing a new technique.

The choice of dose and concentration of ropivacaine is extensively discussed in our paper. The two chosen doses and concentrations are comparable and differ only in the onset of sensory block and offset of motor block, which is explained by the pharmacological properties of prilocaine.

Therefore, we believe that the results of our study are clinically relevant, and the chosen doses and discharge criteria are clinically appropriate.

Conflicts of interest None declared.

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