In Response:

The interpretation by Friedberg that the consensus panel’s emphasis was “heavily biased in favor of antiemetic therapy” is not consistent with the published guidelines: the panel affirms that reducing baseline risk factors are important and constitute effective strategies in reducing the risks for developing postoperative nausea and vomiting (PONV).

In the published consensus, Guideline 1 recommends the assessment of risks for PONV. Guideline 2 outlines strategies to reduce the baseline risks. Among the recommendations include the use of regional anesthesia with local anesthetics as well as the use of local anesthetic infiltration to reduce intraoperative and postoperative opioid requirements. This is followed by Guideline 3, which discusses the options for antimicrobial therapy. The panel believes this is a logical sequence for managing patients to prevent PONV.

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In Response:

Dürsteler et al. suggested that, because ondansetron and droperidol can decrease the analgesic effectiveness of tramadol, these antiemetics should not be used for routine prophylaxis. We would agree that the literature on chronic drug use would support their statement that the “likelihood to develop a pharmacodynamic drug interaction increases exponentially with the number of drugs administered.” However, given the infrequent use of tramadol in the perioperative period for acute pain management (because such a general recommendation should be subject to extensive debate.

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of its relatively weak analgesic efficacy and high incidence adverse side effects, we would seriously question the clinical importance of this potential drug interaction following a single prophylactic dose of either ondansetron or droperidol.

We would agree with Drusteler et al. that dexamethasone would be a very logical choice for antiemetic prophylaxis if tramadol is used for acute pain management in the postoperative period. Furthermore, these authors are correct in arguing that before widespread adoption of our simplified recommendation regarding antiemetic prophylaxis, this practice would ideally be subjected to a large scale, prospective clinical trial.

Finally, postoperative nausea and vomiting remains a significant problem for many patients receiving general anesthesia, and is apparently a major concern of many patients scheduled to undergo elective surgical procedures. A multimodal approach involving a combination of prophylactic antiemetic drugs, adequate hydration and the use of non-opioid analgesic techniques for pain management, remains the best overall solution for minimizing this common side effect in the postoperative period.

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Reducing Epistaxis During Nasotracheal Intubation

To the Editor:

We have several comments regarding the recent paper by Seo et al. showing that inserting an esophageal stethoscope into a warmed preformed tracheal tube reduced the incidence and severity of nasal hemorrhage associated with nasotracheal intubation.

First, using simple preinduc tion clinical tests to estimate the relative patency of the nostrils may not be helpful in determining the more patent nostril. Performing a preliminary bilateral fiberoptic nasendoscopy after the induction of anesthesia, to assess intranasal anatomy and select the best nostril, is significantly more sensitive than tests based on air flow.

Second, we find interesting that when breathing conditions in their patients was equal bilaterally, the selection of the left nostril for intubation was influenced by surgical preference, rather than at random. The mucosa over the lateral turbinates has greater vascularity than the septal mucosa, and the mucosa is not tethered to the underlying bone. The preformed tracheal tubes used in their study had left facing bevels, and during left-sided intubation, the bevel tends to impact directly against the mucosa overlying the lateral turbinate, which can cause bleeding. The observed incidence and severity of epistaxis may have been lower had they selected the right nostril when breathing conditions were equal.

Third, after traditional nasotracheal intubation, fiberoptic inspection of the anterior nose has shown that preformed tracheal tubes preferentially traverse the upper nasal pathway, close to the middle turbinate. The middle turbinate is easily traumatized, so when resistance is encountered during insertion of a tracheal tube to reduce the risk of epistaxis, we believe that the tube should initially be manipulated in a caudal rather than a cephalad direction.

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