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In Reply:—The recent editorial titled “Innocent Prattle”¹ congratulated Dr. Li *et al.* for introducing new methodology to examine the epidemiologic patterns of anesthesia-related deaths at the national level. Specifically, they used *International Classification of Diseases*, 10th Revision (ICD-10) codes to identify anesthesia-related deaths from the multiple-cause-of-death data files maintained by the National Center for Health Statistics for the years 1999–2005. They then calculated death rates from anesthesia complications based on population data and hospital surgical discharge data. Using their innovative methodology, the authors found that the number of anesthesia-related deaths averaged 316 per year and the number of deaths with an anesthesia complication as the underlying cause averaged 34 per year,² for an estimated 30 million anesthetics annually. I also look forward to the application and validation by the scientific community of their techniques to monitor anesthesia safety in the future, but until such time, it is difficult to accept their claims that the United States has experienced a 97% decrease in the anesthesia-related death rate since the late 1940s and that 46.6% of anesthesia-related deaths are attributable to overdose of anesthetics and 42.5% are attributable to adverse effects of anesthetics in therapeutic use.²

It is incredible claims of improved anesthesia safety that previously led to my analogy to *The Emperor's New Clothes* by Hans Christian Andersen.³ Some of our anesthesia community, like the townspeople in the fable, want to believe that we are somehow special, so they blindly accept these claims of improved anesthesia safety. In my analogy, I play the role of the child who is accused of “innocent prattle” by challenging the claims of Dr. Li *et al.* in an editorial of the same name. I apologize to Dr. Li *et al.* if my editorial led them to believe that their work was accused of being prattle. That was certainly not my intention. In fact, I see their role in my analogy as being much more noble.

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Outpatients Do Not Need to Void after Short Neuraxial Blocks

To the Editor:—Baldini *et al.*¹ are to be congratulated for their excellent review of the problem of postoperative urinary retention. It reflects the growing role of the anesthesiologist in perioperative management and enhances our awareness of the impact of our anesthetic techniques on postoperative outcomes. Their description of the anatomy, physiology, and pharmacology of this phenomenon will serve as a reference source for many practitioners.

As an anesthesiologist in the ambulatory setting, however, I have a concern about their generalizations in their concluding page about the requirement for voiding in outpatients after neuraxial blockade. The authors correctly identify in earlier references that the potential for urinary retention is proportional to the duration of the blockade, which they discuss both in their section on the duration of surgery and in their review of spinal anesthetics.^{2–5} They cite our own prospective study that specifically addressed the issue of discharge without a voiding requirement.⁶ These references support the principle that otherwise low-risk outpatients have no greater risk of retention after short duration neuraxial blockade than those receiving general anesthesia, and requiring voiding before discharge may represent an unnecessary delay. Therefore, it is unfortunate that the discussion of outpatient requirements refers only to the policy by Pavlin *et al.*, that spinal and epidural blockade are inherent risk factors for urinary retention.

That conclusion was based on previous publication from Pavlin's group, which demonstrated delayed discharge after spinal anesthetics performed with bupivacaine and lidocaine plus epinephrine.⁷ In their subsequent study of voiding in outpatients, 26 patients received neuraxial blockade: 22 were given either bupivacaine or lidocaine plus epinephrine.⁸ Therefore, their conclusions are consistent with their experience and data, and previous reports regarding long-duration blockade. The publications mentioned above, however, demonstrate that the use of short-duration local anesthetics for outpatient spinal

blockade are not associated with an increased risk of urinary retention for low-risk patients, and thus do not necessarily mandate voiding before discharge. Further work is obviously indicated, but it seems that neuraxial anesthesia alone (with a short-acting drug in a low-risk patient) is not a risk factor for postoperative retention.

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