erences for immediate postoperative recovery. Br J Anaesth 2002; 89:760–1
9. Kerger H, Turan A, Kredel M, Stuckert U, Alsip N, Gan TJ, Apfel CC: Patients' willingness to pay for anti-emetic treatment. Acta Anaesthesiol Scand 2007; 51:38–43
10. Macario A, Weinger M, Carney S, Kim A: Which clinical anesthesia outcomes are important to avoid? The perspective of patients. Anesth Analg 1999; 89:652–8
11. Orkin FK, Cohen MM, Duncan PG: The quest for meaningful outcomes. ANESTHESIOLOGY 1993; 78:417–22
12. Huybrechts I, Barvais L, Ducart A, Engelman E, Schmartz D, Koch M: Assessment of thoracic epidural analgesia during general anesthesia using pupillary reflex dilation: A preliminary study. J Cardiothorac Vasc Anesth 2006; 20:664–7

(Accepted for publication April 22, 2010.)

In Reply:

We thank for Drs. Stites-Hallett and Larson for their comments regarding our article on postoperative pain management.[1] First, we agree that there are different types of hysterectomy (*e.g.*, open abdominal, radical abdominal, laparoscopic-assisted vaginal, and simple vaginal) and nephrectomy procedures. Unfortunately, our discussion on nephrectomy left out the word "laparoscopic." An open nephrectomy will have the same problems as an open colonic resection, where postoperative epidural analgesia is in fact evidence-based. According to the PROSPECT Web site,* the group has concluded, on the basis of the available literature on single modality analgesic interventions for hysterectomy procedures, that in low-risk patients, postoperative epidural analgesia is not cost-beneficial compared with simply using systemic multimodal nonopioid analgesics. However, it may be considered in high-risk patients. Drs. Stites-Hallett and Larson quote many earlier studies on the metabolic benefits of postoperative epidural analgesia; at the time they were published, they were important. However, with modern fast-track methodology,[2] the hospital stay has been minimized, and recovery no longer requires continuous epidural analgesia after hysterectomy procedures. It is true that there are some obvious benefits from intraoperative epidural analgesia with respect to pain control and prevention of postoperative nausea and vomiting in the *early* recovery period. Yet the use of effective multimodal nonopioid analgesia from the time the patient emerges from anesthesia has obviated the need for more invasive analgesic techniques such as epidural analgesia. For more extensive hysterectomies in high-risk patients, a different approach may be appropriate. However, the intention of our article was to give our view based upon the most recent literature. As with practice guidelines, well-argued considerations can justify deviation from these very broad recommendations in specific situations.

Paul F. White, Ph.D., M.D.,† Henrik Kehlet, M.D., Ph.D.
†University of Texas Southwestern Medical Center at Dallas, Dallas, Texas. paul.white@utsouthwestern.edu

References

1. White PF, Kehlet H: Improving postoperative pain management: What are the unresolved issues? ANESTHESIOLOGY 2010; 112:220–5
2. White PF, Kehlet H, Neal JM, Schricker T, Carr DB, Carli F, Fast-Track Surgery Study Group: The role of the anesthesiologist in fast-track surgery: From multimodal analgesia to perioperative medical care. Anesth Analg 2007; 104: 1380–96

(Accepted for publication April 22, 2010.)

* http://www.postoppain.org. Accessed August 12, 2009.