cular lymphocytic inflammation, with 15 diagnostic or suggestive of microvasculitis. Seventeen patients who underwent biopsy were treated with immunotherapy (typically corticosteroids) and, of the 13 who were followed longitudinally, there was a significant resolution of neurologic impairment ($P = 0.001$). Based on these data, the authors concluded that "it is important for physicians to recognize that not all neuropathies that occur in the postsurgical setting are due to compression, transection, or stretch." Inasmuch as the inflammatory response may be altered dramatically during the postoperative period, and inflammatory microvasculitis neuropathy is a previously unrecognized or underrecognized cause of peripheral neuropathy after surgery, large epidemiologic studies will be required to determine the role of this disease entity in the origin of new-onset perioperative neuropathy.

In his criticism of our editorial, Dr. Sosis is mistaken that we were "cavalier" in our assessments. Quite the contrary, we are extremely interested in ongoing research to identify the causes of new-onset perioperative neurologic deficits and remediate any shortcomings in the contemporary delivery of health care. However, we view it as irresponsible, both to the patients and the physicians who care for them, to fabricate origins of patient injury, mislead patients with those fabrications, and downstream place clinicians at inappropriate legal vulnerability. This is not to discount that shortcomings in the delivery of health care—independent of other risk factors—can contribute to adverse patient outcomes. However, attempts to criticize clinicians' shortcomings absent convincing evidence that a shortcoming has occurred serve no one except those who benefit financially from misdirected legal actions or who otherwise advance their professional careers based on unsubstantiated claims.

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Is It Dangerous to Quit Smoking Shortly before Surgery?

To the Editor:

We read with interest the work of Turan *et al.*,[1] who used the American College of Surgeons National Surgical Quality Improvement Program Database and found that cigarette smoking increased risk for perioperative mortality and major morbidity in patients having noncardiac surgery. The accompanying editorial by Katznelson and Beattie[2] provides a valuable perspective on their work, and we applaud their call for anesthesiologists to take a leadership role in efforts to help surgical patients quit smoking. In addition to potential beneficial effects on the acute perioperative risk nicely documented by Turan *et al.*, surgery also represents a teachable moment for smoking cessation (*e.g.*, undergoing a surgical procedure increases the chances that smokers will successfully quit),[3] and the benefits of smoking cessation to long-term health are unquestioned. The issue of the optimal timing of preoperative smoking cessation is of practical importance, and the duration of preoperative abstinence necessary for maximum benefit is not defined (and may differ among various smoking-related complications). For example, recent data suggest that even prolonging postoperative abstinence in smokers who had smoked up to the time of their surgery may benefit patients who have undergone orthopedic surgery.[4]

Unfortunately, in their excellent commentary Katznelson and Beattie perpetuate a concept that hinders perioperative tobacco control efforts: the fear that brief preoperative abstinence from smoking may actually have deleterious effects. They raise the concern that abstinence from smoking may exacerbate preoperative stress, citing a paper from our group that showed that although smokers report more stress than nonsmokers, stress was not increased by perioperative abstinence, and cravings for cigarettes were surprisingly low.[5] This finding actually favors attempts at smoking cessation during the immediate perioperative period, especially when considering the forced abstinence created by smoke-free healthcare facilities. They also state that several studies suggest that patients who experience sudden withdrawal from tobacco may be at increased risk for pulmonary complications, referencing two observational studies to support this assertion.[6,7] However, the study of Bluman *et al.* did not analyze patients who quit smoking shortly before surgery, but rather those who "cut down" the number of cigarettes smoked by a relatively modest amount.[6] The study of Nakagawa *et al.* did not find a significant difference in pulmonary complications between those patients who quit from 2–4 weeks before surgery and those who had smoked within 2 weeks before surgery.[7]

It is beyond the scope of this letter to fully review this topic, but a recent meta-analysis of available studies, which as Katznelson and Beattie note are primarily observational and have sig-

This letter was sent to the author of the above-mentioned article. The author felt that a reply was not necessary.—James C. Eisenach, M.D., Editor-in-Chief

nificant limitations and potential biases, concluded that relatively brief preoperative abstinence from smoking (less than 8 weeks) does not increase pulmonary risk compared with continued smoking.[8] Indeed, we are not aware of any individual study that has found a statistically significant increase in pulmonary complications with brief preoperative abstinence, including the two initial studies by Warner *et al.* that were interpreted by some authors as raising concerns.[9,10] The conjectured mechanism responsible for increased risk is a transient increase in cough and sputum production after smoking cessation. However, there is no evidence that cough and sputum production actually increase after smoking cessation, either in an ambulatory population[11] or specifically in anesthetized patients.[12] It does seem clear that more prolonged abstinence from smoking is necessary to reduce the risk of pulmonary morbidity because it takes several weeks for the lungs to recover from the effects of smoking.[13]

Thus, although more data would be welcome, we do not believe that there is any evidence to support the possibility that short-term smoking cessation increases pulmonary complications. It is very likely that the longer the duration of abstinence the better in terms of reducing risk of pulmonary and other complications. However, given the power of the teachable moment and the long-term benefits to health, anesthesiologists and others should seize any opportunity at any time to help their patients quit smoking, without fearing that brief preoperative abstinence could worsen outcome. The American Society of Anesthesiologists provides several tools to do so.*

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In Reply:

We want to thank Drs. Warner and Shi for the detailed letter in response to our editorial.[1]

We were satisfied to see that we have similar opinions regarding many aspects of the smoking and smoking cessation. Furthermore, in our editorial we cited extensively Dr. Warner's studies in this field.

However, we are surprised that Drs. Warner and Shi interpreted our message as a warning against smoking cessation shortly before surgery. Our goal was to demonstrate that perioperative smoking cessation is a complex problem requiring more research to guide clinical practice.

We support Drs. Warner and Shi in their advocacy of smoking cessation at any stage of a patient's life, including the perioperative period. However, we could not ignore concerns regarding potential side effects associated with abrupt smoking cessation and their possible interference with the perioperative course. We used our editorial as an opportunity to highlight controversial areas in perioperative smoking cessation and call for more high-quality research to enhance our knowledge in this very important perioperative field.

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Risk of Latex Allergy from Pharmaceutical Vial Closures

To the Editor:

We read with keen interest the educational review by Drs. Sampathi and Lerman on perioperative latex allergy in chil-

* Available at: www.asahq.org/stopsmoking. Accessed April 5, 2011.