the study for ethical reasons. We discussed this in the article and expressed this as a limitation. Nonetheless, many patients were anesthetized in the presence of significant risk factors for difficulty, representing the real-life variation in practice and decision making.

We concur with Dr. Nielsen's final point regarding the need to measure and record difficulty in bag-mask ventilation in every anesthetic record. We believe that this ability is greatly enhanced by a good perioperative electronic health record, and we agree that this provides important diagnostic information to guide subsequent airway management decision making. We believe that any grading used to assess bag-mask ventilation should be straight forward and reproducible. The Han scale conveys relevant information and was developed by an iterative process to record clinically important information. Future studies could examine the reproducibility of this scale and variation between providers.

We thank Dr. Calder for his kind comments and thoughtful review of data. Given the low incidence of the primary outcome, the positive predictive value will certainly be very limited. In addition, we agree that the provider must be ready to encounter difficult mask ventilation combined with difficult laryngoscopy even in patients identified as "low risk" by our prediction model. However, the level of preparation should be sensitive to the patients' difficult airway features and reflect the data that are available.

Once again, we are reticent to use our data to guide the management of neuromuscular blockade. As mentioned in the article, there now exist several prospective controlled trials demonstrating that neuromuscular blockade either maintains or improves mask ventilation. Our observational data lacking detailed timing of administration of agents preclude definitive conclusions. However, as detailed in the Results section, several practitioners did note improvement of mask ventilation after administration of neuromuscular blockade.

Competing Interests

The authors declare no competing interests.

David Healy, F.R.C.A., Michael Aziz, M.D., Sachin Kheterpal, M.D., M.B.A. University of Michigan, Ann Arbor, Michigan (S.K.). sachinkh@med.umich.edu

Reference

1. Kheterpal S, Healy D, Aziz MF, Shanks AM, Freundlich RE, Linton F, Martin LD, Linton J, Epps JL, Fernandez-Bustamante A, Jameson LC, Tremper T, Tremper KK; Multicenter Perioperative Outcomes Group (MPOG) Perioperative Clinical Research Committee: Incidence, predictors, and outcome of difficult mask ventilation combined with difficult laryngoscopy: A report from the multicenter perioperative outcomes group. Anesthesiology 2013; 119:1360–9

(Accepted for Publication April 1, 2014.)

Gabapentinoids and Postsurgical Pain: Safe and Effective?

To the Editor:

The recent review on perioperative gabapentinoids by Schmidt *et al.*[1] shows several inconsistencies with the findings of the literature they review. The authors claim that "gabapentinoids are generally very well tolerated," an assertion contradicted by even the most enthusiastic of the three old meta-analyses they cite, where there was a threefold increase in sedation or drowsiness[2]; they also fail to report accurately the findings of a more recent analysis in saying "gabapentin is effective in already established acute postoperative pain even when dosed solely postoperatively."[3] This Cochrane analysis actually says "... but the NNT of 11 for at least 50% pain relief over 6 hours with gabapentin 250 mg is of limited clinical value and inferior to commonly used analgesics." The overall tenor of the review is that gabapentin is substantially effective, both in the management of acute postoperative pain and in the prevention of chronic postsurgical pain. Neither contention is supported by independent analyses.[4*]

Given the early history of inappropriate promotion of gabapentin for off-label use for pain, it seems wise to be particularly vigilant for inconsistencies when assessing the drug's apparent benefits.

Competing Interests

The author declares no competing interests.

Johan M. van Schalkwyk, F.R.A.C.P., Auckland City Hospital, Auckland, New Zealand. johanvs@adhb.govt.nz

References

1. Schmidt PC, Ruchelli G, Mackey SC, Carroll IR: Perioperative gabapentinoids: Choice of agent, dose, timing, and effects on chronic postsurgical pain. Anesthesiology 2013; 119:1215–21
2. Hurley RW, Cohen SP, Williams KA, Rowlingson AJ, Wu CL: The analgesic effects of perioperative gabapentin on postoperative pain: A meta-analysis. Reg Anesth Pain Med 2006; 31:237–47
3. Straube S, Derry S, Moore RA, Wiffen PJ, McQuay HJ: Single dose oral gabapentin for established acute postoperative pain in adults. Cochrane Database Syst Rev 2010; CD008183
4. Chaparro LE, Smith SA, Moore A, Wiffen PJ, Gilron I: Pharmacotherapy for the prevention of chronic pain after surgery in adults. Cochrane Database syst Rev 2013; CD008307.pub2

(Accepted for publication April 10, 2014.)

*Therapeutics Initiative. Gabapentin for pain: New evidence from hidden data. Therapeutics Letter 2009; 75. University of British Columbia. Available at: http://www.ti.ubc.ca/letter75. Accessed November 12, 2013.