

In Reply:

We appreciate Montes *et al.*'s interest in our article. In their 2015 *ANESTHESIOLOGY* article, the authors analyzed data from 2,929 patients who were candidates for inguinal hernia repair (men), hysterectomy (women), or thoracotomy (men) under general, regional, or local anesthesia with sedation. Four hundred and two patients (all male) underwent thoracotomy.¹ Approximately 4.4 months after surgery, 37.6% of the thoracotomy patients had chronic postsurgical pain. We think the size of the study—nearly 3,000 patients enrolled—is quite remarkable.

To summarize the conclusions from Montes *et al.*, they created a multivariate model that included all three types of surgeries where the outcome of interest was the presence of chronic postsurgical pain at 4 months after surgery. According to their model, the following variables were associated with chronic postsurgical pain at 4 months after surgery: (1) surgical procedure, (2) patient age, (3) physical health (Short Form Health Survey-12), (4) mental health (Short Form Health Survey-12), (5) preoperative pain in the surgical field, and (6) preoperative pain in another area.

In our study, we enrolled only thoracic surgery patients (both thoracotomy and video-assisted thoracoscopic surgery) without any restriction on sex. In addition, following the recommendation of the Initiative on Methods, Measurement, and Pain Assessment in Clinical Trials group,² we excluded those patients with preexisting chronic pain problems in the chest area. Preoperative pain in the surgical area and other areas may be different for thoracotomy *versus* hernia and hysterectomy patients. Thoracotomy patients generally do not have preoperative pain in the chest. In our study, preoperative pain at rest was univariately associated with the presence of pain at 6 months after thoracic surgery. However, in the presence of acute pain in the multivariate model, this effect was not significant. We measured preoperative physical function and preoperative mental health with multiple assessments.³ It is likely that those patients with preoperative pain related to their surgical procedure have other psychosocial risk factors before and after surgery, thus limiting comparable studies. There may be unknown risk factors associated with chronic pain for hernia and hysterectomy patients that are not present in thoracic surgery patients, both male and female. In summary, our study and the study of Montes *et al.* are quite different and we cannot make direct comparisons between the factors in their final multivariate model *versus* our model. Differences between Althaus *et al.* and our study are even greater, since only two patients had thoracic surgery in their study.

We recognized our limitations as noted by Montes *et al.* We also noted consistencies with other similar studies.^{4,5} When determining risk factors of postsurgical chronic pain from multiple surgeries, mixing different types of surgeries has a number of limitations, including sex, preoperative symptoms, chronic pain in other areas, and psychosocial risk factors. We agree with Montes *et al.*'s conclusion that larger,

comprehensive, prospective observational studies are needed to confirm and to understand the mechanisms leading to chronic pain after thoracic surgery.

Competing Interests

The authors declare no competing interests.

Emine Ozgur Bayman, Ph.D., Timothy J. Brennan, M.D., Ph.D. University of Iowa, Iowa City, Iowa (E.O.B.). emine-bayman@uiowa.edu

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Keep American Society of Anesthesiologists Physical Status Classification System Simple, Stupid

To the Editor:

We read with great interest the paper of Hurwitz *et al.*¹ that demonstrated more appropriate American Society of Anesthesiologists Physical Status Classification System scores (ASA scores) and reduced interrater variability when the subjective examples provided to the ASA score² were used. We suspect, however, that routine use of these examples may hinder the universal application of the ASA score. First, the examples provided are not fully comprehensive, and they will need to be memorized and easily accessible. Perhaps a mobile app could be created to calculate the correct ASA score, but even this does not guarantee uniform application. Second, as Sweitzer³ emphasized in the accompanying editorial, the universal successful application of