CORRESPONDENCE

In Reply:—Waun states that management of patient-controlled analgesia (PCA) by anesthesiologists fragments perioperative care and increases cost. Our contentions are merely that PCA may not be markedly safer or less complicated to manage than epidural analgesia and that the best-qualified personnel should manage PCA therapy. The application of multidisciplinary expertise of different physician and allied health providers, using an integrated teamwork approach, is one of the great advances of modern medicine and does not necessarily imply a fragmented and uncoordinated approach to patient care.

There is no reason why highly motivated surgeons cannot learn to manage PCA well, but in practice, they are less likely to be either as knowledgeable or as available to patients on the hospital wards as their anesthesiologist colleagues. In addition, any labor-intensive service, such as a very busy PCA service, is unlikely to arouse adequate interest from extremely busy health-care practitioners unless there is reasonable reimbursement for it. We wish this were not true, but it is. Too much of our medical care is driven by economics. We would like to be able to improve postoperative pain management solely on the basis of appeals to our colleagues for "empathetic and compassionate relief of postoperative pain"; it is unfortunate that improving reimbursement will be much more effective.

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Preoxygenation Technique Is Not Ideal

To the Editor:—Keifer and Stirt[1] describe an alternative to standard preoxygenation in which they dispense with the anesthesia mask and place the elbow piece of the anesthesia tubing in the patient's mouth.

We attempted to copy this technique in a trial preoxygenation of five male adult volunteers, employing a circle absorber system with a fresh gas flow of 8 l/min. The expired and inspired gases were monitored at the elbow piece using an Ohmeda Rascal II monitor. Inspired and end-expired fractions of oxygen and nitrogen were measured. It was found that, after 90 s of preoxygenation, the end-tidal oxygen fraction, which equates to alveolar fraction, had reached a plateau at a mean value of 0.622 (range 0.59–0.67).

We know from previous work[2] that efficient preoxygenation using a circle system and mask should result in an end-tidal oxygen plateau approaching 0.9. The failure of the Keifer and Stirt technique to attain full preoxygenation probably is due to air inhalation through the nose. Use of a nose clip would eliminate this problem but may be as unpleasant for patients as the application of an anesthesia mask.

We recognize that efficient preoxygenation is not always easy because of lack of patient compliance but advise caution in the use of the Keifer and Stirt technique in situations that mandate full preoxygenation. The difference between an alveolar oxygen fraction of 0.9 and 0.6 could prevent desaturation for a significant period during a difficult intubation.

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