Optimizing strategies in pancreatic and hepato-biliary surgery

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CHAPTER 4

The Time has Come to Embrace Continuous Wound Infiltration via Preperitoneal Catheters as Routine Analgesic Therapy in Open Abdominal Surgery

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TO THE EDITOR:

With great interest we read the randomized controlled trial (RCT) by Bell et al. on continuous wound infiltration via pre-peritoneal catheters plus patient-controlled opioid analgesia (CWI+PCA) versus epidural analgesia (EA) in patients undergoing open liver resection.

We congratulate the authors on this study and we endorse their conclusion that CWI+PCA is a valid alternative to EA, which is also supported by two prior RCTs and one meta-analysis.2-4

We also would like to highlight and discuss 3 issues. First, the current study found that the anesthesia time was significantly shorter with CWI+PCA compared to EA. The authors, however, did not measure the time needed for wound catheter placement, which is done by surgeons at the end of the procedure. We feel this time should be taken into account as was done in our recent trial.3

Second, the authors may want to clarify their sample size calculation. A simple calculation of the estimated sample size, based on length of hospital stay (mean 9.8 vs. 8.8 days, standard deviation 8.2, power 80%), results in 1056 patients per study arm.5 This is much greater than the sample size of 40 patients per arm presented in the article. Self-evidently, we should interpret the non-significant difference in length of stay with extreme caution, as it may be false-negative (type-II error) result.

Third, no quality of life outcomes or patient-preferences were captured in this study. We would like to stress the importance of including the patients’ perspective in every aspect of our clinical care and research, especially in prospective studies like these. Therefore, we suggest that patient satisfaction or patient-reported outcomes such as the validated Overall Benefit of Analgesic Score (a combination of pain score, opioid side effects, and patient satisfaction)6 should be added to any upcoming pain study.

In conclusion, we learn from this RCT by Bell et al. that CWI+PCA results in adequate pain control after open liver surgery.1 We know that CWI+PCA is more widely applicable (e.g., in patients using potent anticoagulants or for converted laparoscopic or robotic surgery) and bears fewer risks and side effects (e.g., no risk of epidural hematoma or abscess) than EA.5, 7 Until recently, CWI+PCA was only used as the primary form of anesthesia in selected high volume centers for hepato-pancreato-biliary surgery in the United Kingdom and USA. We fully agree with the conclusion of the authors that there is no argument indeed for routine application of EA in open liver surgery or any form of open abdominal surgery. The time has come to embrace CWI via preperitoneal catheters as routine analgesic therapy in open abdominal surgery.
REFERENCES


