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LETTER

Not everything that can be done should be done

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Dear editor

After reading the article, "Thoracic combined spinal epidural anesthesia for laparoscopic cholecystectomy in a geriatric patient with ischemic heart disease and renal insufficiency" by Mehta et al,[1] I have the following considerations. Laparoscopic cholecystectomy was performed under spinal anesthesia in healthy patients.[2] Perioperative hemodynamic instability (59%) and discomfort (43%) were noticed in this group of 49 patients. From the gastroenterology literature, we know that a combination of lumbar spinal and thoracic epidural anesthesia can be used as a monotherapy for high-risk patients undergoing gastrointestinal and colorectal surgery.[3] Perioperative hemodynamics and discomfort were not observed in 12 patients. Is this a stress-free environment? Preventing general anesthesia should not be a goal on its own. From an oxygen delivery-consumption point of view, general anesthesia reduces oxygen consumption and can promote oxygen delivery, theoretically preventing organ failure, especially in high-risk surgical patients with diseases that involve multiple organs.[4] Our body has protected the delicate spinal cord by the vertebral column. Damaging the spinal cord during anesthesia, for instance, during epidural procedures, is one of the greatest fears of our patients and anesthesiologists.[5,6] New techniques should be thoroughly tested on healthy patients before they are used on high-risk surgical patients. A combined thoracic spinal epidural anesthesia is, in the light of the above, an undesirable technique, especially combined with pneumoperitoneum when hemodynamic and respiratory homeostasis and patient comfort can be compromised. Although there is the possibility to place a thoracic combined spinal epidural anesthesia, I strongly like to emphasize that especially in the view of patient safety, this procedure is undesirable. A thoracic epidural combined with general anesthesia is in the most cases (if not all cases) a safe alternative.

Disclosure

The author reports no conflicts of interest in this communication.

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Authors' reply

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Dear editor

We thank Dr Slagt for his interest in our work and the opportunity to reply. We agree to the comment that preventing general anesthesia should not be the goal on its own. However, regarding the questionability of stress-free environment provided by spinal anesthesia, we would like to direct the author's attention to the point that the quoted study[1] used lumbar spinal anesthesia, whereas we used thoracic route to create segmental blockade. Imbelloni et al[2] reported significantly less hypotensive episodes in thoracic spinal as compared to lumbar spinal anesthesia for laparoscopic cholecystectomy. "Less dermatomes blocked, less vasodilatation". Maintaining mean arterial pressure within normal limits in itself is a security against organ ischemia. Regarding the author's comment "New techniques should be thoroughly tested on healthy patients before they are used on high-risk surgical patients", we would like to state that actually reverse has been done with thoracic spinal technique; it was initially reserved for high-risk patients unfit for general anesthesia. Encouraged by the successful management of a patient with end-stage lung disease[3] for laparoscopic cholecystectomy with thoracic spinal anesthesia, van Zundert et al[4] decided to study the feasibility in healthy subjects. Since then many authors[3–5] have reported studies in healthy subjects and till date no reports of neurological damage have been noted. Regarding the safety of thoracic spinal anesthesia, I would like to request the author to go through the detailed discussion of the case report. More detailed discussion on this issue is to appear soon in *Journal of Anaesthesiology Clinical Pharmacology*.

Disclosure

The authors report no conflicts of interest in this communication.

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