to manuscript submission’. We followed all the elements of the CONSORT checklist and reported the CONSORT flow diagram, with the exception of two elements that we would like to clarify here. The study was conducted at Duke University Medical Center in Durham, NC, USA. There was no patient enrollment in Chile; Dr. Lacassie was involved with the study whilst at Duke University Medical Center. The trial was not registered on a public registry, because there was no requirement for registration when the trial started in 2005. Anaesthesia requested registration details during the submission process. The outcome measures of the trial did not deviate from those determined a priori, and are typical for studies investigating changes in postoperative glucose concentrations from baseline.

The 8 mg dose of dexamethasone used in our trial was commonly used for postoperative nausea and vomiting (PONV) at the time we started our study. The consensus guidelines for the management of PONV that were published in 2003 recommended a dose of 5–10 mg [2]. This was subsequently reduced to 4–5 mg in the guidelines published in 2007 and 2014 [3, 4]. While we agree that there does not appear to be a difference in anti-emetic efficacy between the 4 and 8 mg doses of dexamethasone [5], there might still be reasons to use the 8 mg dose in current practice. For instance, improved quality of recovery scores and enhancement of postoperative analgesia have been reported with the use of the higher dose of dexamethasone [6, 7]. The increase in blood glucose following dexamethasone administration might be dose dependent. Our group has recently reported a smaller increase in postoperative blood glucose concentration with a 4 mg dose compared to the 8–10 mg dose of dexamethasone [8]. Therefore, as we stated in our article, the 4 mg dose might be preferred if dexamethasone was used for PONV prophylaxis in diabetic patients.

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Radiation safety for anaesthesia providers

In their review of radiation safety, Rhea et al. discussed the use of lead protection for anaesthesia providers in theatre [1]. The availability of lead protection is seldom an issue in our institution, however we do agree that it is cumbersome to wear, and appropriate sizing is not always possible. Also, we agree that lead gowns do require constant maintenance and checking of their integrity, which does increase the workload of theatre staff.

Methodologically, we were disappointed that the review did not follow the PRISMA guidelines...
regarding the necessity of this gear. It is tantamount to review the evidence sure, but we agree that it is important to prevent radiation exposure in real life. While we accept that these studies show no significant exposure to radiation at this distance, they are unrealistic in that they do not simulate real life; our work involves moving around many parts of the operating theatre at varying distances from the radiation source, often coming closer to the source, for example, to inject drugs, or occasionally to perform intravenous cannulation or airway manipulation. The discussion acknowledges that it was ‘hard to know if that is the exact distance the provider was located for all of the exposures’ in studies that attached dosimeters to subjects; we suggest that this is, in fact, a strength of these studies, as they are more reflective of radiation exposure in real life.

At our institution, we are governed by legislation regarding protective lead gear in the operating theatre to prevent radiation exposure, but we agree that it is important to review the evidence regarding the necessity of this gear. While the authors’ sincerity and good intentions in writing this article are obvious, we would suggest caution in the interpretation of their findings.

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Sugammadex: economic and practical considerations

Loupec et al. evaluated different doses of sugammadex to reverse deep neuromuscular blockade (NMB) with rocuronium in morbidly obese patients [1]. Doses were calculated using ideal body weight (IBW), based on the drug’s hydrophilic properties. This has economic implications, due to the relatively high cost of sugammadex (~€65, ~£74, US$78 for 200 mg in 2 ml, and ~€163, ~£185, US$196 for 500 mg in 5 ml ampoule).

For a 1.75 m tall male patient, total body weight (TBW) 125 kg, BMI 40 kg.m$^{-2}$, IBW of 73 kg [2], the reversal sugammadex dose from deep NMB (4 mg.kg$^{-1}$ of IBW) is 292 mg, or 250 mg (2 mg.kg$^{-1}$ TBW) according to Loupec et al. [1]. Approximately 108 mg of 2 × 2 ml ampoules (~£35, € 40, US $42) or 208 mg of 1 × 5 ml ampoule (~€68, £77, US$82) is wasted. Administering the full ampoule contents (400 mg or 500 mg), however, would deliver nearer the maximal dose of 4 mg.kg$^{-1}$ TBW recommended by the US Food and Drug Administration [3]. Such increased dosage should result in a shorter (dose-dependent) time to complete NMB reversal [4], and reduced incidence of recurarisation [5], without increasing cost.

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