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Dr. Passerini responds

In their letter, Drs. Wong and Findlay raise legitimate concerns of inappropriate interpretations of my study (*Can J Surg* 1996;39:99-104). I recognized the limits of my retrospective analysis and the fact that I could not rule out the role of intensive care unit monitoring in preventing major complications. I suggested that an alternative management for patients who had undergone carotid endarterectomy could be to extend the recovery room stay before deciding on admission to the intensive care unit on the basis of an early occurrence of complications. This suggestion is supported by the observations in other studies.[1-3] My conclusions specifically addressed the issue of "routine admission" to the intensive care unit. I believe that the decision to admit a patient to the intensive care unit should be based on assessment of the patient in the recovery room.

I agree that ideally a prospective controlled trial should be done to evaluate our clinical practices although it would be very difficult to do. With sound medical judgement we can apply current evidence from the literature to prospective evaluation of our practices. I agree that financial incentives have no place in decision making at the bedside. However, I believe that physicians have a social responsibility to use resources to the best of their knowledge rather than their preference, because financial restraints are a reality.

Improvement in anesthetic techniques, including regional anesthesia,[4] and improved surgical techniques allow physicians to manage patients differently. Changes in routine management are always difficult to implement. As a result of our experience, we have applied the recommendations made in my paper to extend the recovery room stay to 6 hours before discharging the patient to the surgical ward or the intensive care unit. Before implementing this change in practice, I and my colleagues held many discussions with staff in the anesthesia department, the vascular surgery service and the intensive care unit and with nursing staff. All patients are assessed by the anesthesiologist and the surgeon in the recovery room; they discuss their decision as to the need for intensive care unit monitoring with the intensivist. We have evaluated our short experience of just a few months with this new protocol: we currently admit to the intensive care unit about 25% of patients who undergo carotid endarterectomy. This is a higher percentage than we expected, probably reflecting our concern to provide "safe" care. We believe there is a learning curve associated with changes in practice. This prospective evaluation is ongoing and should provide further indications for intensive care unit monitoring of carotid endarterectomy.

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