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Author response to "The unexplored role of metoclopramide: a non-opiate analgesic for acute pain management"

Thanks to Dr. Gupta for his response. While I am aware of the use of metoclopramide in the management of migraines, in my practice and literature review I have not seen its application in multimodal post-operative pain control and would be very interested in further research.

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A novel approach for postoperative pain management after discharge

I welcomed the article by Dr. Duncan Rozario, who described the necessary preoperative patient pain education and need for multimodal analgesia in the intra- and postoperative phase.[1] The incorporation of intraoperative regional anesthesia is also highlighted and welcomed from a postoperative opioid-sparing profile. In my experience, surgeons do not always have the experience in managing complex pain patients who then undergo surgery for postoperative pain management. Such patients in my experience have difficulty managing their postoperative pain and frequently visit the emergency department for further pain management or poorly managed pain with escalating opioids. There is also an opportunity, especially with orthopedic trauma, amputation, thoracic and other high-risk surgeries, for patients who have pre-existing factors that increase the risk of developing postoperative surgical pain syndrome.[2] Such patients can be referred preemptively to the acute pain service and for follow-up at a reputable community-based pain clinic or a transitional pain service if available.

My recommendation for improving service provision to help bridge the gap for patients with complex postsurgical pain leaving the hospital back into the community is a transitional pain service such as the one at Toronto General Hospital.

This is a novel clinical model that provides specialized pain management strategies for patients who require care plans and strategies to help facilitate discharge. Patients are then seen in the outpatient setting to help increase functioning, optimize pain control, and receive support.

A transitional pain service team also has the ability to follow patients from the point of preadmitting, before a surgery takes place, to review pain management techniques and to prepare for what can be expected during their hospital stay, education and community support. Community support can be in the form of outpatient clinics, or with follow-up at a local community pain clinic.

Other facets of a transitional pain service are to identify patients with opioid dependency, to minimize adverse effects of pain management and to incorporate a multimodal multidisciplinary care when appropriate. Adverse effects related to opioids include nausea, constipation, sedation, and cognitive issues and may lead to further morbidity and hindrance of recovery.

If there is no transitional pain service available, then attempt to liaise with a community pain clinic for patients to be followed up urgently for complex pain management to facilitate opioid management, rehabilitation services and psychosocial support. This is only possible by developing strong relationships with reputable community pain physicians and clinics.

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Author response to "A novel approach for postoperative pain management after discharge"

Thanks to Dr. Sohanpal for his response. I agree that many surgeons have limited experience in the management of complex pain patients and should consider having these patients seen preoperatively in a pain service setting (such as a transitional pain service) to optimize postoperative outcomes. Patients with issues of dependency, chronic pain, and those on cannabinoids can be challenging to manage after surgery.

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Lever effect and the optical illusion of safety in laparoscopic cholecystectomy

Congratulations to Dr. Sutherland and colleagues for putting words to a problem that we have all felt since the introduction of the laparoscopic approach to cholecystectomy over 30 years ago.[1] Dissection to the left of the extrahepatic bile duct may create the optical illusion of safety. In the early days, many patients who should have had simple cholecystectomy were referred with bile duct injury. I reported to the annual meeting of the general surgery section of the Royal College that it could be due to lack of awareness that the load force at the end of the laparoscopic instrument is greater than the effort force applied to the handle.[2] The lever effect increases the retraction force by the ratio of the length of the instrument outside of the body divided by the length inside, usually about 3:1. The fulcrum, which is the body wall, also permits traction to be applied in the lateral-inferior direction, as described by Sutherland and colleagues, more easily than in open cholecystectomy.

I advise my trainees to ask the critical question, rather than look for the critical view, before they clip and cut anything: Is there a route for this structure (artery or bile duct) to return to the liver? If the answer is yes, the structure might be the right hepatic artery or the extrahepatic bile duct. The area in which the structure might be attached to the liver requires further careful dissection until the team answers no to the critical question.

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Author response to "Lever effect and the optical illusion of safety in laparoscopic cholecystectomy"

I thank Dr. McAlister for his letter commenting on our article. He brings up 2 important points that were not mentioned in the manuscript. The "lever effect" that the long laparoscopic instruments have on increasing the force at the instrument tip is certainly an underappreciated fact. Indeed, this may account for the difficulty many residents have in learning this procedure. Clearly, the harder one pulls on Hartman's Pouch, the more the bile duct kinks, producing an increasingly convincing illusion.

Experienced surgeons develop many tricks that help them avoid mistakes, and these tricks are not mutually exclusive. We routinely use B-SAFE landmarks and the critical view of safety. Many tricks are subconscious and do not get passed on to our trainees. Looking for a route for any structure to return to liver is a "McAlister Wisdom" that we should impart to all our residents.

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