Gabapentin to Prevent Acute Pain after Tonsillectomy
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No sponsorships or competing interests have been disclosed for this article.

We read with great interest the article of Sanders et al in a recent issue of the journal. The authors examined 73 adults undergoing tonsillectomy and concluded that preemptive gabapentin (600 mg) resulted in greater postoperative pain scores and analgesic consumption following adult tonsillectomy when compared with placebo. The authors should be congratulated for performing a well-designed trial in an important topic for patients undergoing tonsillectomy surgery.

Although the study of Sanders et al was designed well, there are some concerns regarding their trial that should be clarified to determine the validity of the study findings. First, it would be important to present the postoperative opioid and nonopioid analgesic consumption by study groups, as this can significantly alter the primary outcome. Second, although the authors listed the common drugs used during anesthesia, the anesthetic management was not standardized, and this can alter the primary outcome. Last, the authors evaluated 2 primary outcomes (pain at rest and swallowing) across 15 time points. The authors should have corrected their P values to avoid type I errors (Bonferroni-corrected P < .001).

We welcome comments to address the aforementioned issues. This would help to further validate the findings of this important study.

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References

Response to “Gabapentin to Prevent Acute Pain after Tonsillectomy”
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Sponsorships or competing interests that may be relevant to content are disclosed at the end of this article.

We would like to thank Kendall and Castro-Alves for their kind letter and the concerns that they raised regarding our study. To address the first point, analysis of postoperative opioid and nonopioid analgesic consumption was performed by study groups in table format; this has been graphically represented and published as part of a thesis available at the University of Otago library, New Zealand. Consumption is shown here in Figure 1. Postoperative analgesia included paracetamol (acetaminophen; 1 g), codeine (30-60 mg), and diclofenac (50 mg). Remaining tablets were returned to verify quantities used, and these showed good correlation to patient-reported consumption.

Disclosures
Competing interests: None.
Sponsorships: None.
Funding source: None.
All participants received intravenous fentanyl (IV) intraoperatively at weight-appropriate dosages; all participants received IV dexamethasone (4 mg), IV ondansetron (4 mg), IV parecoxib (40 mg), and IV clonidine (45 mcg). A further 2 to 4 mg of dexamethasone was administered to participants weighing >90 kg. Many anesthetists favored using a single dose of morphine in addition to fentanyl. Fifteen participants randomized to the placebo group and 11 to the gabapentin group received morphine; all doses were between 5 and 10 mg (Table 1).

Last, regarding the statistical analysis for the primary outcomes, we fitted a linear mixed model with the individual as a random effect (because there are multiple measurements per person) and a quadratic term (because of the shape of the curves representing pain over time). It is not customary or appropriate to adjust for multiple comparisons in a regression context. We are not assessing the difference at 15 time points. We are comparing the response profiles for the 2 groups as a single comparison. This is therefore not considered a series of tests. It is not clear to us how a multiple comparison (in particular Bonferroni) would work in this context.

We hope that these comments satisfactorily address the issues raised. Further well-designed studies are recommended to confirm our findings.

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The anesthetic regimen was controlled as much as possible; a protocol was devised. Among the 17 anesthetists involved in the study, a number preferred to use their usual regimen for tonsillectomy; given the randomization, these variations were evenly distributed between the groups, as would be expected (Table 1). All participants received intravenous fentanyl (IV) intraoperatively at weight-appropriate dosages; all participants received IV dexamethasone (4 mg), IV ondansetron (4 mg), IV parecoxib (40 mg), and IV clonidine (45 mcg). A further 2 to 4 mg of dexamethasone was administered to participants weighing >90 kg. Many anesthetists favored using a single dose of morphine in addition to fentanyl. Fifteen participants randomized to the placebo group and 11 to the gabapentin group received morphine; all doses were between 5 and 10 mg (Table 1).

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