EM training

To the editor: The useful survey presented by Bhimani and colleagues[1] may (or may not) have been confounded by question 6 regarding CCFP(EM) training. It may not distinguish those who have completed a third year of emergency medicine education from physicians who have achieved the CCFP(EM) designation by the practice-eligible route. This, of course, depends on the instructions given to the survey participants.

Seamus Donaghy
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Reference

1. Bhimani M, Dickie G, McLeod S, et al. Emergency medicine training demographics of physicians working in rural and regional southwestern Ontario emergency departments. CJEM 2007;9:449-52.

[The authors respond]

To the editor: As noted, our survey did not distinguish between CCFP(EM) certified physicians who had residency training and those who had practice eligible training. As the College of Family Physicians of Canada treats holders of this designation equally, we would assume that they clinically represent similar practice skills. The CCFP(EM) designation entails passing a rigorous examination, and practice eligible candidates also need to demonstrate many hours of defined emergency medicine work. For the purpose of our survey, any holder of the CCFP(EM) designation would be assumed to have an additional emergency medicine skill set.

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Procedural sedation

To the editor: The article by Zed and colleagues[1] raises some interesting questions. Could it be that contrary to current belief, propofol does have analgesic/amnesic properties? It would be helpful to know which patients (and their procedures) were given fentanyl. Which patients (and procedures) experienced recall? I suggest that 6.2% recall of a painful procedure is unacceptable. The addition of 1 mg to 2 mg midazolam may be a small price to pay for total absence of recall. Since 1 of the goals of procedural sedation in the emergency department is to have the patient "street ready" in the shortest time possible, is it now time to consider the use of alfentanil or, better still, remifentanil, given the brief duration of pain inflicted by the majority of our emergency department interventions?

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Reference

1. Zed PJ, Abu-Laban RB, Chan WWY, et al. Efficacy, safety and patient satisfaction of propofol for procedural sedation and analgesia in the emergency department: a prospective study. CJEM 2007;9:421-7.

[The authors respond]

To the editor: We thank Dr. Donaghy for his letter regarding our paper.[1] It is clear that propofol has very effective amnestic properties, as demonstrated by the lack of procedural recall in 93.8% of patients in our study. Of the 113 patients in our study, fentanyl, the use of which was left to the discretion of the emergency physician, was administered in 19 (16.8%). These 19 patients had a mean age of 40.3 (SD 15.4) years and 73.7% were male. The procedures included 12 orthopedic manipulations, 3 abscess incision and drainages, 2 chest tube insertions, 1 foreign body removal and 1 incarcerated hernia reduction. Recall was absent in 17 patients (89.4%).

Overall, recall was reported in 7 patients (6.2%); 3 reported a pain score of 0 on a 10-point visual analog scale, and the remaining 4 patients reported pain scores of 2, 4, 4 and 5, respectively. Among the 4 patients that reported recall and pain, 2 (50%) (both shoulder dislocations) were given 100 mcg of fentanyl prior to the administration of propofol.

Dr. Donaghy raises intriguing questions regarding the appropriate use of analgesics in the setting of procedural sedation and analgesia (PSA). The current literature on this aspect of propofol suggests further study is required.[2] Our study does little to clarify the situation, since only 4 patients (3.5%) reported recall and pain, and one-half of them received fentanyl, underscoring the difficulty in predicting the analgesic requirements in this patient population. A recent study published in abstract form by Miner and colleagues[3] evaluated the

role of alfentanil with or without propofol in patients undergoing PSA and found no difference in the propofol dose, time of procedure, changes from baseline end-tidal CO_2 or hypoxia. However, there were more supportive airway measures required in the patients who received alfentanil (34.1% alfentanil/propofol v. 12.8% propofol alone, $p = 0.02$). Clearly this area requires further study, not only to determine which opioid analgesic is the optimal agent, but also whether routine analgesia is necessary at all in the setting of PSA performed with propofol.

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1. Zed PJ, Abu-Laban RB, Chan WWY, et al. Efficacy, safety and patient satisfaction of propofol for procedural sedation and analgesia in the emergency department: a prospective study. CJEM 2007;9:421-7.
2. Miner JR, Krauss B. Procedural sedation and analgesia research: state of the art. Acad Emerg Med 2007;14:170-8.
3. Miner JR, Stephens D, Plummer D, et al. Randomized clinical trial of procedural sedation using propofol with and without the ultra-short acting narcotic alfentanil [abstract]. Acad Emerg Med 2007;14:S58.

Fluoroquinolones and arthropathy in children

To the editor: The present study by Forsythe and Ernst[1] did not take into consideration the difference between the various quinolones as far as the occurrence of arthropathy is concerned. Among the quinolones, significant differences have been observed between agents, with levofloxacin and pefloxacin being associated with more arthropathy than ciprofloxacin, enoxacin, moxifloxacin and rufloxacin ($p < 0.01$).[2] Also, the cumulative dose at which arthropathy occurs is not clear from this article.

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References
1. Forsythe CT, Ernst ME. Do fluoroquinolones commonly cause arthropathy in children? CJEM 2007;9:459-62.
2. Leone R, Venegoni M, Motola D, et al. Adverse drug reactions related to the use of fluoroquinolone antimicrobials: an analysis of spontaneous reports and fluoroquinolone consumption data from three Italian regions. Drug Saf 2003;26:109-20.

Letters will be considered for publication if they relate to topics of interest to emergency physicians in urban, rural, community or academic settings. Letters responding to a previously published *CJEM* article should reach *CJEM* head office in Vancouver (see masthead for details) within 6 weeks of the article's publication. Letters should be limited to 400 words and 5 references. For reasons of space, letters may be edited for brevity and clarity.

Les lettres seront considérées pour publication si elles sont pertinentes à la médecine d'urgence en milieu urbain, rural, communautaire ou universitaire. Les lettres en réponse à des articles du *JCMU* publiés antérieurement devraient parvenir au siège social du *JCMU* à Vancouver (voir titre pour plus de détails) moins de six semaines après la parution de l'article en question. Les lettres ne devraient pas avoir plus de 400 mots et cinq références. Pour des raisons d'espace et par souci de concision et de clarté, certaines lettres pourraient être modifiées.

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