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Comments on Published Article: A valuable resource

The Indian Journal of Anaesthesia (IJA) publishes Letters to the Editor in every issue. These are short, decisive communications, usually not exceeding 600 words, and may be case reports, comments on published articles, responses to comments, brief descriptions of new or innovative techniques, reports of complications of equipment or adverse drug reactions encountered in practice, or general topics of interest to the readers. All Letters undergo a peer review process similar to Original Articles or Case Reports. Between January 2017 and May 2018, one hundred and fifteen Letters to the Editor were published in the IJA. While the majority (68 out of 115; 59%) were reports of clinical cases, 14 letters (12%) were comments on articles published in previous issues of the IJA and nine articles (8%) were responses to these comments [Figure 1].

The submission and publication of comments on published papers and responses to comments is a welcome trend. It facilitates debate and discussion between authors and readers, and is a clear sign that articles in the IJA are being read! The section is a mechanism for submitting comments, questions, or usually criticisms about published articles.^[1] Authors are given an opportunity to respond to these

comments, and it is their responsibility to do so. This healthy debate and discussion helps improve communication between the journal, its readers, and authors. Despite external peer review and editorial review, some concerns may be raised about aspects of an article after it has been published, including the study methodology, accuracy of data, or conclusions drawn. Constructive criticism, disagreement, and debate are integral to science and medicine. Hence, pointed, concise, and pertinent comments on published articles are welcome; comments that are rude or derogatory in tone and content, fault finding and nitpicking in nature, that are vague and do not have an important message or make a good point are not welcome! Comments should be specific rather than general, and should be based on data and evidence rather than personal opinions or beliefs, and must adhere to the norms of good scientific writing.^[2]

In this issue of the IJA, three articles comment on a study published by Goyal *et al.* in the March 2018 issue of the IJA regarding avoidance of reversal of neuromuscular blockade in patients in whom objective neuromuscular function monitoring was carried out.^[3] In that study, two cohorts of patients were studied; one cohort was exposed to objective, quantitative neuromuscular monitoring (NMM) intraoperatively and at extubation, whereas in the other, no NMM was performed. The groups were allocated based on the surgery list of that day; every alternate patient had NMM and other alternates on same day did not receive NMM. The authors observed that, in patients in whom objective NMM was performed, the trachea could be safely extubated when the train-of-four (TOF) ratio was allowed to reach 0.9 without using neostigmine. They concluded that, with use of objective, quantitative NMM, the use of anticholinesterases could be avoided. In response, Tak and Prateek,^[4] Mehandale *et al.*,^[5] and

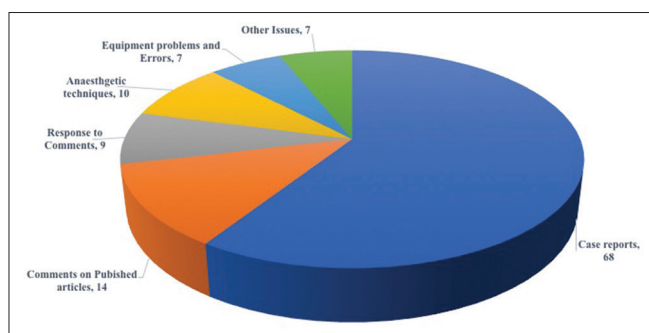


Figure 1: Types of the Letters to the Editor ($n = 115$) published in the Indian Journal of Anaesthesia between January 2017 and May 2018

Bhalotra^[6] have written letters expressing concern regarding the study design, the dose and timing of rocuronium administered, the end points used, and above all, challenged the conclusion that routine use of neostigmine could be avoided. In response, Goyal *et al.* defend their study with a point-to-point rebuttal of the comments, and re-iterate that with objective NMM, the TOF ratio can be allowed to recover to >0.9 without anticholinesterases.^[7]

Why did this study evoke so many responses? I believe that the study, despite its imperfections, challenges conventional dogma. The idea of not giving an anticholinesterase to reverse residual neuromuscular blockade borders on heresy. Ideas that challenge convention must necessarily be subjected to scrutiny and challenged, but must also be given the opportunity to mount a defense. Residual neuromuscular blockade is undesirable and is associated with several postoperative adverse effects and complications.^[8] The risk of residual neuromuscular blockade is present even with intermediate-acting neuromuscular blocking agents such as vecuronium or rocuronium as well as atracurium. Hence, reversal of residual neuromuscular blockade is clinically sound. However, Goyal *et al.*^[3,7] and others^[8,9] suggest that, if neuromuscular function is being objectively monitored, it may be safe to allow the neuromuscular function to recover to a TOF ratio >0.9 without giving neostigmine. If neuromuscular blockade is not being objectively monitored with a device that displays the TOF ratio, neuromuscular blockade should always be reversed with neostigmine, as suggested in the three letters^[4-6] and by others.^[9]

The points and counterpoints made in the original article, the comments in the three letters and the response of the authors give the readers a good overview of the issues surrounding reversal of neuromuscular blockade. The IJA serves as a forum where all these views, put responsibly and scientifically, can be

expressed. It is ultimately for the readers to draw their own conclusions and practice safe clinical anaesthesia, based on the information in these articles, their own interpretation of the data in the literature, their experience, and their circumstances.

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