LETTER TO THE EDITOR

Reckoning the Inhaled Sedation in Critically Ill Patients (INSTINCT) Study

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Dear Editor

The inhaled sedation in critically ill patients (INSTINCT) I Study published in your esteemed journal bears uniqueness, and being the first of its kind from India, it carries a high value in the field for the subcontinent.[1] The study is timely and well conducted, and we applaud the authors' effort and commendable work. While the authors have given an extensive description of the methodology and presented the results very well, it is felt that a bit of information on procedural and economic aspects will benefit the readers, practitioners, and future researchers further.

The sedation level of the patients was very well assessed using an accurate and objective scale, i.e., Richmond Agitation Sedation Scale (RASS). The authors have targeted the sedation to RASS – 3 (moderate) to 4 (deep). While it is not uncommon to target deep sedation in critically ill patients in exceptional situations, the usual practice and recommended sedation for mechanically ventilated patients are up to light sedation RASS – 2.[2,3] It is inconclusive whether deeper sedation is associated with increased delirium;[4] but, considering ventilation duration and lack of benefit in context to airway-related adverse events for deeper sedation over lighter one, a calm patient with lighter sedation is advocated.[3,5] While it is agreed that the management of intensive care unit (ICU) patients is multi-dimensional and needs patient-specific titration, the patients included in the study were postoperative patients with cancer. Such patients are otherwise not critically ill (underwent elective surgery); the rationale behind the decision to keep deeper sedation levels in such patients will benefit the practitioners and future research.

Further, sedation is a continuum of the depth of anesthesia. Age can significantly impact the inhalational anesthesia depth as measured in minimum alveolar concentration (MAC), even with the same end-tidal concentration of the agent.[6] The authors have recruited patients between 18 and 80 years, a vast range where MACage is likely to differ significantly. As the authors have used an anesthesia gas monitor, the readers will benefit if they present the end-tidal concentrations and MACage data.

Finally, the cost of any health intervention is a crucial aspect to be considered for health-care delivery, especially in a country with a relatively poor economy and per capita health expenditure. The technique employed for inhalational sedation requires the conserving device as well as a few consumables. It will be helpful to know the average per-patient cost of the 24 hours sedation in the authors' cohort.

Nevertheless, the authors' study has opened a new horizon for future research in the cost, benefits, and specific patient groups for using inhalational sedation in ICU. We thank the authors for the same.

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