

Letter to the Editor

Comment on “Pregabalin Effect on Acute and Chronic Pain after Cardiac Surgery”

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We have read with great interest the article entitled “*Clinical Study: Pregabalin Effect on Acute and Chronic Pain after Cardiac Surgery*” by Bouzia et al. [1]. We appreciate their effort for this clinical study, and we would like to make some comments as we believe that there are some flaws in its design and methodology.

First, it is not mentioned when exactly the patients received the single dose of the “study drug” and if there was any delay in the extubation time. In other studies, the results were unstable as time to extubation was significantly longer in the pregabalin group [2, 3] or similar between groups [4, 5].

The visual analogue scale (VAS) and numeric rate scale (NRS) are equally sensitive in assessing acute pain after surgery, and they are both superior to VRS, but the authors chose to use the verbal rating scale (VRS) for assessment of pain intensity, although they finally describe the numeric rate scale. It is remarkable that VRS can be converted to numeric scores for charting and easy comparison, but the authors did not mention or explain this option.

We think that the whole plan of postoperative analgesia has many limitations. First, it is not clear when the patients received the initial dose of morphine (5 mg). Also, they preferred to use a background infusion with the programmable PCA pump and a too long lockout interval combined with a bolus dose of 0.5 mg morphine. Additionally, they provided rescue analgesia with IV morphine if the above scheme with the pump was not sufficient.

It is well known that chronic pain after cardiac surgery is multifactorial and according to the authors with only one dose of pregabalin the patients in the pregabalin groups experienced less severe postoperative pain, used less analgesics, and

reported less sleep disturbances without explaining which pain assessment tools they used and if the assessment was done at rest or at stress. Also, it is remarkable that many patients after cardiac surgery may have neuropathic pain characteristics, and it is appropriate to use not only chronic pain assessment tools but also neuropathic pain screening tools such as DN4 [6].

In our opinion, all these limitations may be responsible for their results. More studies and especially well-designed clinical trials are required in order to clarify the optimal dose, the duration of therapy, and the benefits and risks before adopting pregabalin in routine clinical practice and especially in patients undergoing cardiac surgery. Until then, the results may not be as ideal and promising as it sounds.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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