Low-dose ketamine for analgesia in the ED: a retrospective case series

To the Editor,

Laeben et al reported a study about low-dose ketamine for analgesia in the emergency department (ED) [1]. However, there was concern about the patient group in this study which may interfere with their conclusion when applied to the general population. Twenty-eight (80%) of the 35 studied cases had the record of chronic pain medication use or illicit drug abuse. As far as our ED is concerned, patients with these records represent a very different issue of analgesia from that of ordinary people. Tolerance or dependence of opioids or opioid-like agents was frequently seen in these patients, which make them become a “drug seeker” in the ED, and thus, analgesia or so-called improvement of pain for them is more complicated. When doing our study, we tried to analyze the characteristics and behaviors of patients with such records. The strategy for pain management for them is also different. As a matter of fact, the magnitude of pain or whether it is improved after medication is totally subjective. Being a drug seeker or not, they might really experience vigorous pain when appearing at the ED, although they were seeking opioids or opioid-like agents most of the time. Usually, a nonsteroidal anti-inflammatory drug, such as ketoprofen for most cases, will be given at first. If no improvement or worsening of the pain was complained of, then suspicion of drug seeking would be raised. Patients might sometimes even ask for opioids or name the drug penthidine (Demerol), which is uncommon in a non-English country, thereby identifying themselves as drug seekers. For patients with drug-seeking records, use of opioids or opioid-like agents may be restricted or even prohibited by the drug administrative committee of our hospital after official discussion. Therefore, they might ask for other alternatives for temporary relief. We have one case that used to dislocate his hip joint just to receive heavy sedation during close reduction after he was on the list.

Besides the high incidence of chronic pain medication use or illicit drug abuse, opioids were used in all the cases, which makes the result more unreliable. Opioids were administered before or with ketamine in 32 (91%) of 35 cases, and the remaining 3 patients were on long-acting opioids or had used heroin near their visit. Under such conditions, it is very difficult to tell whether the improvement of pain could be attributed to the low-dose ketamine, or if those reporting no improvement were asking for more medication. The authors did not describe the detail of the “additional pain medication” given to patients with insufficient pain improvement in the text, but it showed they are morphine and Dilaudid, a morphine derivative, in 6 cases according to Table 1. The unusually high-dose and multiple injections of morphine in case 23 with abscess indicated that its usage is very probably nothing to do with pain, especially when no level of pain before or after ketamine was recorded. Although pain is often overlooked or undertreated in the ED, as mentioned by the authors, the reason for pain control in this study is also confusing. Apart from the 3 cases of fracture, abscess composed 46% of the single chief complaint, which seldom needs pain control no matter whether incision and drainage were done, and its coexistence with heroin use makes the indication of opioids and ketamine for analgesia more unclear. Other cases with cellulitis, a condition seldom needing pain control other than oral nonsteroidal anti-inflammatory drugs, make their complaints of pain even more unreliable. Opioids, together with low-dose ketamine in this study truly for analgesia or just for drug addiction relief, deserve further discussion. Although the authors declared that this was the first description of low-dose ketamine for analgesia in the ED and carefully limited their conclusion to patients with high narcotic tolerance, either the patients characteristics or the unexceptional appearance of opioid use makes the true effect of analgesia and the role of ketamine in this study questionable.

Tsung-Ying Lin MD
Wei-Che Lee MD, MS
Department of Trauma
Kaohsiung Medical University Hospital
Kaohsiung Medical University Hospital
Kaohsiung 807, Taiwan
Department of Emergency Medicine
Kaohsiung Medical University Hospital
Kaohsiung Medical University Hospital
Kaohsiung 807, Taiwan
E-mail address: p620822@yahoo.com.tw

Ching-Ying Wu MD, MS
Department of Dermatology
Kaohsiung Medical University Hospital
Kaohsiung Medical University Hospital
Kaohsiung 807, Taiwan

doi:10.1016/j.ajem.2010.10.018

Reference

Left circumflex artery thrombosis in the era of sensitive troponin assays

To the Editor,

As shown in the recent study [1], and in other studies [2-5], there is a high probability that patients with left circumflex artery (LCx) thrombosis will fall into the category of non-ST-segment elevation myocardial infarction (NSTEMI), and this is true also when diagnostic