A subanesthetic dose of oral ketamine proved able to reduce chronic pain. These findings support the idea that norketamine, a metabolite of ketamine, may have played an important part in the analgesia observed in these chronic-pain patients, although we did not measure the plasma concentration of norketamine. We did not observe serious adverse events or tolerance to oral ketamine in the present study. Oral ketamine may be useful for the long-term treatment of chronic neuropathic pain.

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References

Hemodynamic effects of stellate ganglion block: analysis using a model of aortic input impedance

To the Editor:
It has been suggested that a left SGB is not associated with hemodynamic alterations, whereas a right SGB significantly alters hemodynamics. Yet, clinical studies evaluating the hemodynamic effects of unilateral right and left stellate ganglion block (SGB) in humans are lacking. The thermodilution technique is the most accepted clinical method to estimate cardiac output, but a pulmonary artery catheter is required for as long as cardiac output monitoring is needed. The Portapres Model-2 (TNO Biomedical Instrumentation, Amsterdam, The Netherlands) is a continuous non-invasive hemodynamic monitor. Stroke volume is calculated by the Modelflow

<table>
<thead>
<tr>
<th>Patient</th>
<th>Sex</th>
<th>Age</th>
<th>Duration of pain</th>
<th>Placebo</th>
<th>Oral ketamine</th>
<th>Present dose (mg·day⁻¹)</th>
<th>Side effects</th>
<th>Duration of ketamine therapy (months)</th>
<th>Side effects</th>
<th>Duration of ketamine therapy (months)</th>
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<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>57</td>
<td>2 yr</td>
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<td>87</td>
<td>70</td>
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<td>85</td>
<td>58</td>
<td>211</td>
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<tr>
<td>2</td>
<td>M</td>
<td>25</td>
<td>2.5 yr</td>
<td>82</td>
<td>56</td>
<td>2</td>
<td>1</td>
<td>86</td>
<td>55</td>
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<tr>
<td>3</td>
<td>M</td>
<td>70</td>
<td>10 yr</td>
<td>85</td>
<td>90</td>
<td>-</td>
<td>-</td>
<td>85</td>
<td>65</td>
<td>9</td>
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<tr>
<td>4</td>
<td>M</td>
<td>54</td>
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<td>45</td>
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<td>2</td>
<td>3</td>
<td>40</td>
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<td>12</td>
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<tr>
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<td>F</td>
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<td>6</td>
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<td>F</td>
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<tr>
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<td>67.9</td>
<td>2.5</td>
<td>2.5</td>
<td>77.6</td>
<td>49.1*</td>
<td>1.5</td>
</tr>
</tbody>
</table>

CRPS = complex regional pain syndrome; PHN = postherpetic neuralgia. P < 0.05 (a Wilcoxon signed rank test).
method that estimates beat-to-beat cardiac output from the arterial pressure wave by simulating a non-linear three-element model of aortic input impedance.\textsuperscript{1,2} The tracking of changes in cardiac output is precise.\textsuperscript{3,4} We investigated the real time changes in hemodynamic variables after SGB in patients free of cardiovascular disease.

The study group comprised 21 patients with peripheral facial palsy. A right SGB was induced in ten patients and a left SGB in 11 patients. Hemodynamic variables included blood pressure, stroke volume, cardiac output, heart rate and total peripheral resistance. After the subject had rested in the supine position for ten minutes, left or right SGB was induced with 6 mL of 1% mepivacaine hydrochloride using the paratracheal anterior technique with the needle aimed at the transverse process of the sixth cervical vertebra. Hemodynamic variables were measured for 30 min after SGB.

SGB was successful in all patients. Stroke volume and cardiac output increased slightly but not significantly after left SGB. The average systolic blood pressure decreased by 13.6 mmHg 10–20 min after right SGB and the average mean blood pressure decreased by 6.9 mmHg 15 min after the block. The average stroke volume and cardiac output decreased by 9.4 mL and 0.790 L·min\textsuperscript{−1} respectively five to 30 min after the block (Figure). As a result, the total peripheral resistance increased at ten minutes and at 20–30 min after the block. The heart rate decreased slightly but the difference was not statistically significant.

In conclusion, right SGB appears to have greater hemodynamic consequences than left SGB as assessed by a model of aortic input impedance. There is a possibility that right SGB may worsen cardiac function in patients who already have a cardiovascular compromise.

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References

Decreased neck mobility and postoperative complications
To the Editor:
Recently I was unfortunate enough to have undergone two general anesthetics at a large Canadian teaching hospital. I was seen and interrogated preoperatively by both the staff and senior resident anesthesiologist. I remembered to mention that when lying supine my occiput does not make contact with the surface upon which I lie. I lack full extension of my cervical spine. My first anesthetic was carried out with a laryngeal mask without incident.

Unfortunately, before the second anesthetic, despite answering a lengthy interrogation, I forgot to mention the problem with my neck. I have subsequently been given to understand that, for whatever reason, it was not possible to place a laryngeal mask. Accordingly, I was intubated.