Etomidate for induction of the septic patient

Editor—We commend Eissa and colleagues’ review article; however, we wish to draw attention to the selection of induction agent for septic patients. The ideal haemodynamic properties of etomidate use in this population are countered by lingering concerns about subsequent impaired adrenal steroidogenesis with its attendant consequences—a situation described as an ultimate Faustian bargain. Two recent systematic reviews have examined effects of single-dose etomidate in critically ill patients, and those with suspected sepsis. They both conclude that single-dose etomidate is associated with transient suppression of the adrenal axis. However, neither study reported a significant effect of etomidate on mortality. In fact, no prospective randomized trials to date have reported that etomidate has a significant adverse effect on mortality in patients with sepsis. We feel that while uncertainty remains, consideration should be given to using alternative induction agents, such as ketamine, in the patient with severe sepsis.

Conflict of interest

None declared.

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Reply from the authors

Editor—I appreciate the authors comments on our review article. The articles they cite support the case for etomidate use, on the grounds that there is little evidence of any detrimental effect other than transient adrenocortical suppression. Ketamine is also indicated in the induction of the haemodynamically compromised septic patient. However, I fear that formal comparison of these two agents in a randomized controlled trial with mortality or even major system dysfunction as an outcome measure would be extremely difficult to achieve.

Conflict of interest

None declared.

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Reply from the authors

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Anaesthetic management of patients with severe sepsis

Editor—We read with interest the review article on the anaesthetic management of patients with severe sepsis. While informative, we were disappointed that no reference was made to the use of activated protein C (APC). This would be particularly relevant to the consideration of neuraxial blocks. The only real benefit we can see with epidural catheters in septic patients taken to critical care postop is to aid with weaning. However, epidurals on a background of sepsis is not only high risk but may preclude the use of APC which might be potentially life saving at a later stage. Although initial enthusiasm for APC has waned, the Surviving Sepsis Guidelines 2008 still recommends that adult patients with sepsis-induced organ dysfunction associated with a clinical assessment of high risk of death receive APC if there are no contraindications. We hope that the results of the two current randomized controlled trials underway (one funded by the French government due to be completed in March 2012 the PROWESS-SHOCK trial will address the issue of APC and severe sepsis. Until this time, we believe that the placement of epidural catheters in patients with severe sepsis should be discussed with the on-call intensivist before insertion.

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