preoperative consultation. Lord Bridge warned that defining what "a reasonable person in the patient’s position" would consider a risk of sufficient magnitude that he should be told about it, would prove impractical, unrealistic and meaningless, and lead to unpredictable outcomes [2]. His warning appears to be supported by the findings of our survey.

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Effect of nabilone on nausea and vomiting

Sir,—We read with interest the study undertaken by Lewis, Campbell and Barrowcliffe [1] in which they compared the effects of preoperative oral metoclopramide and oral nabilone on postoperative nausea and vomiting in patients undergoing total abdominal hysterectomy. We wish to comment on this study.

First, they have used a treatment of a formal control group receiving placebo, as opposed to using the findings of a previous survey regarding postoperative vomiting only after total abdominal hysterectomy, would have been most valuable. This would have provided a standardized baseline for interpretation of the results of the study, especially as there are no previously published reports on the use of cannabinoids for the treatment of postoperative nausea and vomiting, as noted by the authors. Second, it has been demonstrated that the oral bioavailability of a 10 mg dose of metoclopramide varies between 52% and 97% [2] whereas that of nabilone 2 mg is 96% [3]; hence, in a group of patients receiving a fixed dose of oral metoclopramide, there is likely to be significant inter-patient variation in serum concentrations of the drug. In addition, in the treatment of cisplatin-induced vomiting using high-dose metoclopramide, it has been demonstrated that in patients responding to this antiemetic therapy, a clear plasma concentration-antienetic effect relationship can be shown [4]. Third, it is interesting to note that in the recovery room, patients who had received metoclopramide before operation had higher nausea and vomiting scores and statistically significant increased opioid use than patients who had received nabilone. In the postoperative period, pain, opioid administration, and nausea and vomiting are linked, although opinion differs as to whether or not pain itself is associated with postoperative nausea and relieved by opioids [5] or whether parenteral opioids are associated with nausea. The difference in recovery room opioid requirements between the two groups of patients may be a manifestation of the analgesic effect of nabilone; this may make an indirect contribution to the antiemetic activity of the drug either by inherent analgesia or by an opioid-sparing effect.

Nabilone offers an effective alternative in the treatment of patients who experience chemotherapy-induced nausea and vomiting which is refractory to conventional therapy [7]. It will be interesting to see whether or not there is a role for nabilone in the treatment of postoperative nausea and vomiting. Further studies involving both single-dose and multiple-dosing schedules will be necessary before this can be decided.

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Sir,—The study of Lewis, Campbell and Barrowcliffe [1] illustrates the difficulties of studying potential antiemetic drugs in a small number of patients. A total of 53 patients divided into two study groups is inadequate given the complex and multifactorial nature of postoperative nausea and vomiting (PONV). The authors calculated an 80% postoperative risk of having a nausea [3] which is published only in abstract [1], and another [2] which is nothing in the literature to date on nabilone that suggests it was likely to produce a 50% improvement above and beyond that achieved by one of the more established agents (i.e. metoclopramide).

More importantly, the level of power chosen by Lewis, Campbell and Barrowcliffe assumes that the two groups of patients are adequately standardized. While the authors have standardized for potentially important factors such as age, gender, operation, postoperative opioids, etc, there is no mention of previous history of either motion sickness or PONV. Of these, current evidence suggests the latter is the more serious omission. As long ago as 1964 Purkiss [2] noted a three-fold increase in PONV during the first 24 h after operation in patients with a previous history of PONV. In two recent large prospective studies [3,4], previous history of PONV has been identified as an important determinant of subsequent risk of PONV, on a par with female gender and use of opioids. Since the current study by Lewis, Campbell and Barrowcliffe failed to standardize for this important fixed patient factor, they cannot conclude that "nabilone is no more effective than metoclopramide as a postoperative antiemetic in women undergoing abdominal hysterectomy".

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Sir,—Toner and Strunin suggest that we have studied an inadequate number of patients. However, as they have observed, we achieved what is widely regarded as a reasonable level of statistical power to demonstrate what we regarded as a worthwhile potential reduction in the incidence of postoperative nausea and vomiting (PONV). They go on to cite two large studies, one of which is published only in abstract [1], and another [2] which is described by the authors as having small numbers and thus low statistical power. The latter authors concluded that their findings "may need to be interpreted with caution when the model is applied to types of surgery having strong associations with postoperative sickness. " It is difficult to think of an operation that is followed by a greater incidence of PONV than hysterectomy.