Author's response to reviews

Title: Prediction of postoperative pain after radical prostatectomy

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Cower letter for the revised manuscript with the title “Prediction of postoperative pain after radical prostatectomy”, “

On of the authors Björn Sjöström died in August and therefore we have no e-mail address to him.

• The stylistic issues have been corrected. We have made the changes regarding the VAS as an acronym both in abstract and background as follows; Visual Analogue Scale (VAS).

• The following paragraph has been added to the Background section (page 4 and 5) “Nurses are in a unique position to supervise and assist patients in pain and in the treatment thereof, considering the extensive time nurses spend with the patients when compared with other health-team members (Nash et al., 1999). Nursing pain management involves a number of activities; assessing pain and deciding whether to administer analgesics, selecting one of different analgesics and choosing the route of administration. Nurses are also responsible for monitoring the effect of medication which is prescribed and administered in a variety of ways, including PRN (pro re nata, as needed/requested), EDA and ITA (Manias, 2003)”.

• The second purpose of the study has been further explained. See page 5, paragraph 2, sentence 2 “The influence of previous pain score (Visual Analogue Scale, VAS-value) on the next-coming pain scores has not earlier been studied in this group of patients i.e. if patients who are in pain directly after surgery continue to be in pain during the postoperative recovery.”
The timeline is now described in the Methods section, first sentence. “The study was a prospective, explorative study conducted from January 2003 to June 2004.”

The finding that preoperative anxiety tended to correlate with postoperative pain has been removed from the text.

We have added a headline “Limitations” (page 16) where we discuss the issues that are pointed out by the reviewer.

The link between nursing and patients’ pain is discussed on page 15, section 2.

The last paragraph on page 9 has been revised. Hopefully the text is now more logic.

All references to tables are moved to the “Result” section

Only four patients reported some kind of pain before surgery as described under the heading “Pain expectations and pain experiences”, page 9, last sentence. Therefore the correlation between pre- and postoperative pain was not analyzed.

The references are now correct

Baseline pain scores were 0 except for four patients and therefore we did not use this factor in the univariate analysis. The findings of the correlation between pain at 4h, day 1 and day 2 is important because it seems like patient in pain at 4 hours continue to be in pain and should be treated in the immediate postoperative phase.

The patients were not assigned to different pain treatment methods depending on patient factors. As described on page 8 under the heading “Procedure”, sub-heading “Pain treatment routines”, initially EDA was the routine treatment for postoperative pain in these RP patients. About a year after the beginning of the study, and after evaluating EDA as an ineffective method for pain treatment in this group of patients, the method for postoperative analgesia was shifted to ITA. Study patients who were deemed unsuitable for either EDA or ITA, received systemic opioids for pain relief.

The section “Statistical methods” is now extended.

This text has been added to the “Discussion” section. From a treatment perspective we wanted to predict whether the patient needs treatment in the next future, so that we, in
the best case, can give the treatment before the pain has increased above 30mm on the VAS scale. For that purpose we did not need to make a prediction at baseline or by use of the baseline values. We needed to make a prediction with a time horizon of a few hours only to get the opportunity to treat the patient.

I think that the University of Gothenburg has an agreement with you about payment for publication of articles.

Sincerely

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