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Comment on: "Low-Dose Ketamine for Outpatient Hysteroscopy."

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Dear Editor,

I read the article about the anaesthetic management of office hysteroscopy procedures (1) published in the April 2020 issue with great avidity. I appreciate the efforts of the authors to analyse the efficacy of low-dose ketamine as an alternative to the conventional pentazocine-promethazine combination used in their institute (1). I wish to make certain remarks about the article, which will perhaps enlighten the readers further about this study.

The authors have observed that the low-dose ketamine group required significantly lesser rescue analgesic dosage than the control group, besides providing better hemodynamic stability and surgeon and patient satisfaction (1). However, the method adopted to provide rescue analgesic dosage raises some questions. Rescue analgesic in the form of intravenous 0.5 mcg kg^{-1} fentanyl was administered if the visual analogue scale (VAS) scores were more than 3 either during the procedure or 2 hours after the procedure. The authors stated that 2 patients in the low-dose ketamine group required rescue analgesic, and the VAS score could not be assessed in this group during the procedure, which lasted about 30 minutes. It is not clear whether these 2 patients required rescue analgesic during or after the procedure because it is difficult to interpret it from the results of VAS scores provided. This is because the VAS scores were provided as mean values with standard deviation with the highest one being 2.0±0.9 at 45 minutes for this intervention group. Moreover, we cannot use a tool (VAS) reliably, if it is feasible in one group and not at all in the other group for a certain period, as we know pretty well that ketamine administration (albeit in low dose) would prevent the patient from providing VAS scores, especially in the case of this study (1) where the primary aim was to assess the pain during the procedure. Hence, it is not surprising that the overall pain scores were comparable between the two groups. Furthermore, the clinical signs of ketamine administration, as well as the inability of the patient to provide VAS scores, would have certainly negated the "Blinding" of the investigator(s) too.

The pain scores remained comparable in the post-procedure phase too. This could be because the procedure was endoscopic without any incision, hence, it did not make much difference regardless of ketamine or pentazocine administration. Consequently, most of the requirements of rescue analgesic should have occurred during the procedure itself in the control group.

I also believe that it would have been better if the authors had focused on the time taken for "readiness to travel to home" between the two groups because the study was conducted on the day-care procedure.

There is also a possibility of pentazocine (agonist-antagonist) countering the effects of subsequent fentanyl (pure mu agonist) administration to some extent and thereby increasing its requirements further at least in some patients.

Regarding the secondary outcomes of this study that include the satisfaction of the patient, the surgeon and the nurse, the authors have quoted an article (2). However, this referenced article (2) has analysed only patient satisfac-

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tion and has nothing to do with the satisfaction of the surgeon or the nurse. Furthermore, the authors of this study (1) have used a 3-point scale for all these 3 satisfaction scores, whereas, Vivas et al. (2) have used the Quality of Recovery Scale consisting of 3 domains with a total of 14 items for patient satisfaction.

Finally, I wish to point out a typographical error in the abstract section in which the p-values are mentioned together for 2 different parameters, namely, pain scores and rescue analgesic requirements.

Peer-review: Externally peer-reviewed.

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