Despite these limitations, to the authors' knowledge, this is the first study to examine signs of distress that develop after extubation to comfort care in neurologically devastated patients. The findings from this descriptive study could help educate not only palliative care physicians but also any physician who will be caring for patients extubated to comfort care from the Neuro-ICU on what they could possibly expect in the development of signs of distress. This could hopefully change how providers approach patients who are planned for extubation to comfort care in terms of premedication or post-extubation liberalization of medications.

Conclusion

Almost 74% of patients extubated to comfort in the Neuro-ICU are likely to develop signs of distress requiring pharmacologic intervention; and of these patients who develop signs of distress, over 70% will develop persistent signs of distress that will be difficult to control.

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Response to "Prophylactic Fentanyl Sublingual Spray for Episodic Exertional Dyspnea in Cancer Patients: A Pilot Double-Blind Randomized Controlled Trial"

Dear Editor:

We read with great interest the recent paper titled, "Prophylactic fentanyl sublingual spray for episodic exertional dyspnea in cancer patients: A pilot double-blind randomized controlled trial" by Hui et al.,[1] which reported the results of a pilot double-blind randomized controlled trial comparing the effect of two dose schedules of fentanyl sublingual spray for exertional dyspnea.

The authors reported that the use of a high-dose fentanyl sublingual spray was associated with a significant within-arm reduction in modified Borg scale dyspnea intensity between the first and second shuttle walk test. The results of their study are useful and may influence the management and assessment of dyspnea in our nursing practice. Under the assumption that morphine and oxycodone had better effects on dyspnea than did fentanyl, we—as nurses—considered whether a partial or complete switch to morphine or oxycodone was possible when patients using fentanyl experienced dyspnea. Such a clinical strategy has been reported recently, with similar findings.[2] Nevertheless, if a high-dose prophylactic fentanyl reduces exertional dyspnea, we

would like to proactively implement its use before meals, before patients use the restroom or bathroom, or before walking.

It is important to focus on the use of this prophylactic fentanyl for the palliation of dyspnea. The authors, Hui et al., state that an adequately powered placebo-controlled trial will be conducted to assess the usefulness of the prophylactic fentanyl. We eagerly look forward to the results.

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Authors' Response to: Prophylactic Fentanyl Sublingual Spray for Episodic Exertional Dyspnea in Cancer Patients: A Pilot Double-Blind Randomized Controlled Trial

Dear Editor

We appreciate the comments from Kako and colleagues. At this time, there is still a paucity of literature to inform the opioid of choice for management of dyspnea. To our knowledge, randomized trials examining the prophylactic use of opioids for episodic dyspnea in cancer patients to date have only involved fentanyl.[1-5] No head-to-head comparison of opioids has been conducted for this indication.

Similar to the use of opioids for pain management, we hypothesize that opioids given at equianalgesic doses may have similar efficacy for dyspnea relief. However, there may be interindividual variations and pharmacogenomic predictors of response.[6] For prophylactic administration, fentanyl is particularly attractive given its rapid onset. For example, the time of onset for fentanyl sublingual spray is only 10 minutes,[7,8] in contrast to over 30 minutes for most immediate-release opioids. Ultimately, more research is needed to define the appropriate opioid, dose, and timing of administration for different types of dyspnea.

Although we are encouraged by our preliminary findings, our pilot study was not adequately powered for between-arm comparisons. Until larger randomized trials can confirm the benefits, the use of prophylactic opioids for dyspnea should be considered experimental.

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