megaly with a spleen extending 12 cm beyond the costal margin. A combination of NYHA class 2 shortness of breath and signs of right heart failure with severe tricuspid regurgitation led to the decision for intraoperative monitoring with TOE.

There being no contraindications and with informed consent obtained, an ATL multiplane TOE probe was inserted uneventfully after induction of anaesthesia. A problem was noted when obtaining transgastric views. Added traction through the gastrosplenic ligament to an already stressed splenic vascular pedicle caused the surgeon difficulty with haemostasis whilst ligating these vessels. Because of this the probe was withdrawn, relieving the problem and allowing the surgeon to achieve haemostasis and complete the procedure successfully.

A literature search using Medline revealed no reports of splenomegaly associated with potential problems during use of TOE.

One should bear in mind the close anatomical relationship of the gastrosplenic ligament and the splenic vessels lying within the lienorenal ligament[2] when performing TOE during splenectomy for splenomegaly.

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Pain scores in the early postoperative period

Dr Pfizner and Professor Moyes raise some important issues with respect to management of pain using opioids in the immediate postoperative period[1].

We agree that it is unrealistic to expect that patients will not feel pain after surgery. However, "pain" or "comfort" scores are a valuable tool in tracking a patient's response to treatment. The aim should be patient comfort, both at rest and with movement. This can be explained to patients at the time they are seen before surgery. If patients are informed about the way in which their pain will be assessed and managed at this time, we do not believe that the use of "pain" rather than "comfort" scores makes a patient focus on the pain more.

However, the authors highlight an important point in the use of pain scores and "associated use of reputable 'Pain Protocol' regimens" when they suggest that "conscientious persistence" in the use of both may result in some patients receiving excessive opioid doses. The aim of treatment should be patient comfort in the absence of clinical signs of excessive opioid dose. All nursing staff administering the "Pain Protocol" regimens (small doses of intermittent intravenous opioids) must be aware of the importance of sedation and understand both its significance (increasing sedation being a more reliable clinical indicator of respiratory depression than a decrease in respiratory rate) and how to monitor it properly. It may not be possible to get patient comfort without excessive sedation and at this stage an anaesthetist should be consulted for advice. Our "Pain Protocol" specifically states that administration of opioids should "cease when the patient is comfortable" (they will not necessarily be pain-free) and that no further opioids can be given by the nurses unless the patient has a sedation score of less than 2. With our system a sedation score of 2 means that the patient is moderately drowsy, i.e. they wake easily but cannot stay awake. Administration of any sedative, even for an "overly anxious" patient with inadequate analgesia, is inappropriate.

As with any drug where titration is required, clinical endpoints that can identify both inadequate and excessive dosing are needed. If these are used when opioids are administered, regardless of drug or route, patients who become "over-narcotized" in the recovery ward should be very rare.

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Pain scores in the early postoperative period—Reply

We are grateful for the opportunity to comment on the letter from Dr Macintyre and Professor Russell. Their letter, like ours, highlights the need for "comfort" scores rather than "pain" scores in the management of pain following surgery. We do believe also that the use of "comfort" scores will lessen the risk of