Egyptian Journal of Anaesthesia 33 (2017) 313

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Egyptian Journal of Anaesthesia

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Preoperative intranasal dexmedetomidine versus intranasal ketamine for prevention of emergence agitation after sevoflurane in myringotomy patients: A randomized clinical trial

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Dear Prof. Raghuraman

I really appreciate your effort and I wish to thank you for your letter in response to my article, entitled: Preoperative intranasal dexmedetomidine versus intranasal ketamine for prevention of emergence agitation after sevoflurane in myringotomy patients: a randomized clinical trial.

1. **Regarding the reference number 6 in my article** (Chen J, Li W, Hu X, Wang D. Emergence agitation after cataract surgery in children: a comparison of midazolam, propofol and ketamine. Paediatr anaesth. 2010; 20(9): 873–9.) it **was wrongly cited, the correct citation is** (Abu-Shahwan I, Chowdary K. Ketamine is effective in decreasing the incidence of emergence agitation in children undergoing dental repair under sevoflurane general anesthesia. Paediatr Anaesth. 2007; 17(9): 846–50.)
2. **Also, the reference number 9** (Khattab AM, El-Seify ZA, Shaaban A, Radojevic D, Jankovic I. Sevoflurane-emergence agitation: effect of supplementary low-dose oral ketamine premedication in preschool children undergoing dental surgery. Eur J Anaesthesiol. 2010; 27(4): 353–8.) **was wrongly cited, the correct citation is "**Soliman R, Alshehri A. Effect of dexmedetomidine on emergence agitation in children undergoing adenotonsillectomy under sevoflurane anesthesia: A randomized controlled study. Egyptian Journal of Anaesthesia (2015); 31, 283–9.". **So, in the discussion, the sentence "Each of ketamine[5,6,22] through intravenous route and dexmedetomidine[7–9] through the intravenous route were used" must be corrected to be "Each of ketamine[5,6,22] through intravenous route"**.

***These corrections have been sent to Elsevier Researcher Support team**

3. **In the sentence in the discussion section "According to the study of Iirola and his colleagues[23] dexmedetomidine administered intranasally has good bioavailability and its effects were similar to those of intravenous route, was well tolerated, and its maximal effect was after 45–60 min and, (17) myringotomy is a minimally invasive surgery so, pain is excluded as a causative factor for EA" The reference number 17 is correctly cited here as although Cimen et al. in their conclusion did not point to the duration of action of intranasally administered dexmedetomidine they found 45 min after drug administration that satisfactory sedation score was found in 100%, satisfactory sedation at parental separation in 74% and the mask acceptance was good or excellent in 80.7% of the intranasal group compared to the buccal group during induction of general anesthesia**.

Contribution

Study design and, conduct of the study, data analysis and manuscript preparation.

Publication category

Letter to the editor.

Conflict of interest

None.

Funding source

Self funded.

References

6 Abu-Shahwan I, Chowdary K. Ketamine is effective in decreasing the incidence of emergence agitation in children undergoing dental repair under sevoflurane general anesthesia. Paediatr Anaesth 2007;17(9):846–50.
9 Soliman R, Alshehri A. Effect of dexmedetomidine on emergence agitation in children undergoing adenotonsillectomy under sevoflurane anesthesia: a randomized controlled study. Egypt J Anaesth 2015;31:283–9.
17 Cimen ZS, Hanci A, Sivrikaya GU, Kilinc LT, Erol MK. Comparison of buccal and nasal dexmedetomidine premedication for pediatric patients. Paediatr Anaesth 2013;23(2):134–8.
23 Iirola T, Vilo S, Manner T, Aantaa R, Lahtinen M, Scheinin M, et al. Bioavailability of dexmedetomidine after intranasal administration. Eur J Clin Pharmacol 2011;67(8):825–31.

Peer review under responsibility of Egyptian Society of Anesthesiologists.

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http://dx.doi.org/10.1016/j.egja.2017.04.001