It's our opinion that a greater observance of palliative care should be given, not only during undergraduate training but also through greater research, thus augmenting the comprehension and susceptibility for healthcare professionals while also yielding a better care for the patient.

## REFERENCES

1. Cardoso A, Jolley D, Regan A, Tapley M. Dying with dementia: a challenge for palliative care now and in the future. Acta Med Port 2014;27:414-6.

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**Reply to the Letter in relation to: Ana Cardoso, David Jolley, Ann Regan, Michael Tapley. Dying with Dementia: a Challenge for Palliative Care Now and in the Future. Acta Med Port 2014;27:414-6.**

**Keywords:** Dementia; Continuity of Patient Care; Community Health Service; Terminal Care; Palliative Care; Aged; England.
**Palavras-chave:** Demência; Continuidade de Cuidados ao Doente; Serviço de Saúde Comunitário; Cuidados Terminais; Cuidados Paliativos; Idoso; Inglaterra.

Dear colleagues, thank you for sharing your reflections on the care of your patients with incurable cancer, which were motivated by our article 'Dying with Dementia: A challenge for Palliative Care Now and in the Future'.[1] We agree with your emphasis on holistic approaches, including the psychological social and spiritual elements, both in the assessment of patients needs and in the choice of management approaches that might be suggested.

Cecily Saunder's first patients had cancer, and from her pioneering work the modern palliative movement developed. This article examines these same principles of care extended to people living with dementia, and it is interesting that it has motivated further reflection in oncology about how you cope with divergent expectations among patients and health professionals.

Doctors are traditionally trained in biomedical models of care with increasing emphasis on single system medical specialisation. This may not best suit patients subject to complex co-morbidities and frailty on a background of a life-limiting illness, whether that be a cancer or dementia or both.

Sometimes patients and families complain of hearing mixed messages from the many different specialists treating their illnesses about risks and benefits of treatment and possible outcomes and prognosis.

We agree that palliative principles should be a core theme in medical training for all doctors, and not simply confined to the training of specialists. Physicians who appreciate the interplay between scientific analysis and a person's psycho-spiritual awareness may enable the patient and their family to make informed contributions to decisions about their care.

Palliative medicine may help the patient to see illness in the context of their lives as a whole, and help us share with them their hopes and fears for the future.

Thank you for your encouragement for us all to continue this task.

## REFERENCES

1. Cardoso A, Jolley D, Regan A, Tapley M. Dying with dementia: a challenge for palliative care now and in the future. Acta Med Port 2014;27:414-6.

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**Letters to the Editor Concerning the Article: Alexandre Oliveira Ferreira, Andrea Riphaus. Propofol to Increase Colorectal Cancer Screening in Portugal. Acta Med Port 2014;27:541-42.**

**Cartas ao Editor Relativas ao Artigo: Alexandre Oliveira Ferreira, Andrea Riphaus. Propofol como Forma de Aumentar o Rastreio Endoscópico do Cancro do Cólon e Reto em Portugal. Acta Med Port 2014;27:541-42.**

**Keywords:** Colorectal Neoplasms; Hypnotics and Sedatives; Propofol; Endoscopy, Gastrointestinal; Colonoscopy.
**Palavras-chave:** Neoplasia Colo-Rectal; Hipnóticos e Sedativos; Propofol; Endoscopia Gastrointestinal; Colonoscopia.

Ao Editor,

O artigo de Alexandre Oliveira Ferreira e Andrea Riphaus intitulado 'Propofol como Forma de Aumentar o Rastreio Endoscópico de Cancro do Cólon em Portugal', publicado em Acta Médica Portuguesa[1] merece-nos os seguintes esclarecimentos:

1. O Propofol é um fármaco utilizado em Sedação e em Anestesia. Caracteriza-se por rápido início de ação e curta semivida de eliminação. Não existe fármaco antagonista.

A dificuldade em estabilizar o nível de Sedação por médicos não treinados na administração ou desconhecedores do perfil farmacológico do Propofol, se associado a incapacidade de reconhecer situações de Urgência/Emergência e resolvê-las atempadamente, implica riscos para a segurança do doente.[2,3] Face a tal insensatez e imprudência se pronunciaram 21 Sociedades Nacionais de Anestesiologia da Europa.[4]

2. O Colégio de Anestesiologia da Ordem dos Médicos emitiu Recomendações sobre 'Sedação e Anestesia fora do Bloco Operatório' (2 setembro 2011) e o Colégio de Gastroenterologia produziu um Comunicado recomendando 'aos médicos gastroenterologistas que não aceitem, em simultâneo com a execução de Colonoscopias, realizar por

sua responsabilidade a sedação aos utentes, já que essa tarefa deverá competir a outro profissional médico' (15 março 2014). Os profissionais de enfermagem estão impedidos de proceder a prescrições terapêuticas. Em Portugal a Sedação é um ato médico.

3. Os Anestesiologistas e os seus órgãos representativos têm como paradigma a segurança dos doentes, a minimização de riscos e a capacidade técnica e científica para prevenir e resolver complicações. A segurança do doente assume prioridade integral.[5]
4. Os aspetos económicos referidos assumem áreas de corporativismo e de usufruto de vantagens económicas consideradas inaceitáveis e até ofensivas sob o ponto de vista deontológico.
5. A criação de um curriculum nacional padronizado destinado a aprendizagem e treino em Sedação será desejável, desde que adaptado à realidade portuguesa e seja aprovado pelos respetivos órgãos técnicos e científicos.

## REFERÊNCIAS


1. Ferreira AO, Riphaus A. Propofol to increase colorectal cancer screening in Portugal. Acta Med Port. 2014;27:541-42.
2. Wertmann T, Riphaus A. Sedation with Propofol for interventional endoscopic procedures. Scand J Gastroenterol. 2008;43:368-74.
3. Linden P. Sedation in gastrointestinal endoscopy: an anesthesiologist's perspective. Digestion. 2010;82:102-5.
4. Periel A. Non-anaesthesiologists should not be allowed to administer Propofol for procedual sedation: a Consensus Stament of 21 European National Societies of Anaesthesia. Eur J Anaesthesiol. 2011;28:580-4.
5. Mellin-Olsen J, Staender S, Whitaker DK, Smith AF. The Helsinki Declaration on Patient Safety in Anaesthesiology. Eur J Anaesthesiol. 2010;27:592-7.



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**Keywords:** Colorectal Neoplasms; Hypnotics and Sedatives; Propofol; Endoscopy, Gastrointestinal; Colonoscopy.
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Editor:

We believe that the article by Ferreira AO and Riphaus A[1] should not have been published. The article presented the conclusion that colonoscopy under sedation with propofol performed by non-anaesthesiologists improves screening of colorectal cancer in Portugal. We doubt the validity of this statement and all the author's rationale is biased, misquoting scientific evidence and ending with misleading conclusions.

The authors may have their own opinion regarding the possibility of non-anaesthesiologists perform sedation using propofol for digestive endoscopy but they cannot omit information and rise extremely serious and unproven accusations. First, the authors should refer that after proper discussion among executive and deliberative organs, and consensual rejection of national societies of Anesthesiology, the European Society of Anaesthesiology (ESA) retracted the endorsement of the guideline-non-anaesthesiologist administration of propofol for gastrointestinal endoscopy in 2012,[2,3] but they only refer a temporary endorsement. Secondly, the authors declare that anaesthesiologists are moved by 'financial aspects protecting a multi-million business…'. This statement constitutes an unacceptable, extremely serious accusation and deserves an absolute rejection and condemnation.

Anesthesiology was the first medical specialty to call for patient safety as a specific focus, with a significant decrease in mortality and morbidity caused by anaesthesia administration. Our major concern is that patient safety is not assured when a non-anaesthesiologist manages a drug like propofol: in opposition to authors´ statement, side effects of propofol, including respiratory and cardiocirculatory depression, are not theoretical and may occur even in patients ASA I and II. We cannot accept that the same person performing endoscopy is simultaneously administering propofol, monitoring the patient vital functions and, if necessary, managing the patient´s airway; we cannot also accept the idea that a *sedation educational program* is the miraculous solution for nurses (endoscopy nurses? anaesthesia nurses without medical supervision?) education.

The authors may argue with the open mind allegory, but they have to be cautious to avoid the brain to fall out: facing the equally shortage of digestive endoscopy in our country, are the authors agreeing with a proper training program for non-gastroenterologists professionals to perform endoscopic procedures for screening purposes?

We call to the Editorial Board's attention to the serious statements done by the authors and we strongly claim the retraction of this text.

## REFERENCES


1. Ferreira AO, Riphaus A. Propofol to increase colorectal cancer screening in Portugal. Acta Med Port. 2014;27:541-2.
2. Pelosi P, Board of the European Society of Anaesthesiology. Retraction of endorsement: European Society of Gastrointestinal Endoscopy, European Society of Gastroenterology and Endoscopy Nurses and Associates and the European Society of Anaesthesiology Guideline--non-anaesthesiologist administration of propofol for gastrointestinal endoscopy. Eur J Anaesthesiol. 2012;29:208-9.
3. Perel A. Non-anaesthesiologists should not be allowed to administer propofol for procedural sedation: a Consensus Statement of 21 European National Societies of Anaesthesia. Eur J Anaesthesiol. 2011;28:580-4.



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**Keywords:** Colorectal Neoplasms; Hypnotics and Sedatives; Propofol; Endoscopy, Gastrointestinal; Colonoscopy.
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