

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 anaesthesiologist's perspective. *Digestion.* 2010;82:102-5.
4. 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.
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.

Joaquim FIGUEIREDO LIMA¹

1. Colégio de Anestesiologia. Ordem dos Médicos. Lisboa. Portugal.

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

Editor:

We believe that the article by Ferreira AO and Riphaus A¹ 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.

Francisco ALMEIDA LOBO¹, António RODRIGUES MELO²

1. Serviço de Anestesiologia. Hospital Geral de Santo António. Centro Hospitalar do Porto. Porto. Portugal.

2. Serviço de Anestesiologia. Hospital Escala. Braga. Portugal.

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

Editor,

In a recent paper, Ferreira and Riphaut¹ advocate the use of propofol for sedation of patients during colonoscopy not only by the pharmacokinetic characteristics of this compound, which gives it great versatility to adjust the depth of sedation to the endoscopy, but also by the security they attribute to propofol, stating that 'Propofol sedation has been gaining momentum in the last decade in several European countries but is still underused in most countries. There are several reasons behind this phenomenon. One is the theoretical possibility of clinically significant side effects that include respiratory and circulatory depression, despite the evidence gathered so far, that understates that nonanesthesiologist administration of propofol is as safe as endoscopist directed 'traditional sedation', as shown in several meta-analysis'. These dangerous statements deserve some pharmacological comments.

1 - Propofol side effects of respiratory and circulatory depression are not theoretical possibilities, as the recent death of Michael Jackson, sadly testifies the dangerous respiratory depression induced by propofol.

2 - Propofol is a GABA mimetic drug, which like thiopental hyperpolarizes neurons by an increased chloride conductance, which causes a dose-dependent depression of the central nervous system, varying from a simple sedation to an anesthetic coma and death. For this reason, propofol is classified as a general anesthetic, in the same pharmacological group as thiopental, which is used in anesthesia, but also as a lethal injection for criminal executions. Unlike thiopental, propofol is rapidly cleared, which makes it suitable not only for induction of anesthesia but also for its maintenance as well as for long-term sedation.

3 - The anesthetic coma resultant from the central nervous system depression implies several dangers: 1) cardiovascular depression, 2) depression of the respiratory center (ranging from bradipnea to apnea), 3) relaxation of the oropharyngeal muscles that may induce also obstructive apnea in patients with predisposing airways (retrognathia, obesity, short/thick necks or a history of heavy snoring or sleep apnea), and finally 4) the absence of airway's protective reflexes predispose to the aspiration of HCl from gastric regurgitation or vomiting.

Jones et al² in an excellent video published by The New England Journal of Medicine, considers sedation to be a continuum with three different levels. 1 - Minimal sedation provides a drug-induced state of anxiolysis during which patients respond normally to verbal commands. 2 - Moderate sedation or analgesia, or conscious sedation, is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands when aroused by the sound of a voice or light tactile stimulation. No interventions are required to maintain a patent airway during conscious sedation. 3 - Deep sedation or analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully after the administration of repeated or painful stimulation.

Having in mind the pharmacological profile of the drugs used to sedate patients, Jones aware that invasive or painful procedures require this deep sedation and that the ventilatory function may be impaired during deep sedation.

Jones also recommend that the procedure should be contraindicated when the patient has a history of allergic reaction to analgesic or sedative medications, has unstable cardiorespiratory function, or is in a nonfasting state. Patients undergoing conscious sedation should have had no liquids by mouth for 2 hours before the procedure and no food for 6 to 8 hours before the procedure. Finally, Jones et al. advises that "since sedation is a continuum and a patient's level of sedation can change rapidly, the clinician should have the ability to monitor the patient's level of consciousness, hemodynamics, ventilation, and oxygenation. The patient must have a working intravenous catheter before conscious sedation is initiated. Emergency equipment for intubation and resuscitation must be immediately available, and the clinician must know how to use this equipment and how to administer appropriate medications in case cardiopulmonary resuscitation is required.

I agree that the use of propofol is a very good choice for sedation, but we must be aware of adverse effects and we must never neglect the danger.

REFERENCES

1. Ferreira AO, Riphaut, A. Propofol to increase colorectal cancer screening in Portugal. Acta Med Port. 2014;27:541-2.
2. Jones DR, Salgo P, Meltzer J. Conscious sedation for minor procedures in adults. N Engl J Med 2011;364:e54.

Fernando MARTINS DO VALE¹

1. Institute Pharmacology/Neurosciences and Bioethics Department. Faculty of Medicine. University of Lisbon. Lisbon. Portugal.

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

Palavras-chave: Neoplasia Colo-Rectal; Hipnóticos e Sedativos; Propofol; Endoscopia Gastrointestinal; Colonoscopia.

Rui Tato Marinho
Editor-in-Chief
Acta Médica Portuguesa

I write to support the comments of Ferreira and Riphaut regarding propofol administration by non-anesthesia specialists.¹ Endoscopist supervision of propofol administration by trained registered nurses is safe and remarkably cost-effective,² and has been successfully instituted in Switzerland and Germany. Endoscopist supervised propofol is particularly safe for colonoscopy, which does not need the greater depth of sedation often required for upper endoscopy.² Propofol can be titrated to moderate sedation by combining it with low doses of opioid and/or midazolam.³ This approach further enhances its safety for administration by non-anesthesia personnel.

Fernando MARTINS DO VALE

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

Acta Med Port 2014;27:794-795

Publicado pela **Acta Médica Portuguesa**, a Revista Científica da Ordem dos Médicos

Av. Almirante Gago Coutinho, 151
1749-084 Lisboa, Portugal.

Tel: +351 218 428 215

E-mail: submissao@actamedicaportuguesa.com

www.actamedicaportuguesa.com

ISSN:0870-399X | e-ISSN: 1646-0758



ACTA MÉDICA
PORTUGUESA

