Clinical practice advisory: emergency department procedural sedation with propofol.
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Commentary:

There is no abstract to print here. We suggest all providers interested in the ongoing debate over the use of propofol (in general) might want to read this practice advisory in its entirety. The authors discuss indications, contraindications, fasting states, personnel, pharmacology, monitoring, adverse reactions, recovery and discharge, and future research questions relating to propofol sedation in the ED setting. It is not our purpose to quibble with the conclusions the authors make from the available data, but we think there are a couple of points to make vis-à-vis the methodology used to produce this guideline with respect to pediatric patients: 1) Most concerning is the fact that this practice advisory apparently applies to all age patients (uniformly) – there is essentially no differentiation of children from adults in any of the areas of discussion mentioned above. In fact there is very little mention made of children at all. Under the section relative to "higher relative risk patients" (under the heading "age"), the only mention made of children is the fact that "the distribution and clearance of propofol in children are noted to be similar to that in adults". No mention is made of the possible differences in risk profile of newborns vs. infants vs. toddlers vs. children vs. adults. As yet there simply is not enough data available (in the relatively few studies) that have looked at propofol sedation in children in the ED to make firm conclusions on these age differences; but lack of evidence does not mean that no difference exists, and evidence from other practice situations indicates that children *are* different from adults. We believe possible differences in practice technique deserve at least a mention in the body of this widely disseminated guideline. In another example, under dosing indications, the recommendation is for a dose of 1mg/kg followed by 0.5 mg/kg every 3 minutes as needed - the same for both children and all adults. This recommendation is made in spite of the fact that several studies are cited in this same section that clearly indicate higher doses are needed in children to reach clinical effect for many procedures. To their credit at the end of the paper the authors recognize that future research is needed into age differences – but this does not change the fact that the practice advisory draws conclusions without the benefit of this (to be developed) data. 2) Under "personnel" section the authors propose that a separate MD monitoring the patient may not be needed. This statement is based on one study in which a single physician sedated 250 patients with propofol without a physician monitor (and the adverse event rates were similar to those reported for 2 physician sedation). They conclude "there is no current evidence to suggest that propofol is unsafe without a second physician present". In fact, there ***is no*** meaningful data on this issue at all – one way or the other. Once again, we would suggest that lack of contrary evidence does not prove a point. More data is needed on this issue before any conclusion could be made. It is somewhat concerning that this kind of reasoning would be used in a publication that has as much weight in the emergency medicine community as this one does – and concerning a topic where the stakes are as high as they are in this case.