To the Editor:

We are grateful to Dr. Trikha for the opportunity to comment on the possible benefit of EMLA cream (Astra USA, Inc; Westboro, Mass) and on some aspects that were not treated sufficiently in our article.1 Our work was exclusively aimed at quantifying pain during arterial or venous puncture to obtain blood samples and emphasizes the convenience of using anesthesia in the arterial puncture. The study did not include cannulation, a procedure that is generally longer and more painful.

In our study, previous anesthetic infiltration did not make the localization of the artery difficult. In the cases of arterial puncture without anesthesia, the blood sample was obtained at first attempt in 90% of cases. When a previous infiltration of anesthetic or placebo was done, the sample was obtained at first attempt in 93% and 91% of cases, respectively. Subjects in the study group were exclusively adults (age, 60±12 years).

We have evaluated the anesthetic effects of the EMLA cream2 by applying it to 51 patients and comparing the effects in a random, double-blind manner with those of a placebo cream applied to another 52 patients of similar characteristics. Using the previously described method of quantifying pain,1 the average intensity of pain for the group with anesthetic cream was 2.6 (1.8) cm and that for the placebo group was 2.9 (1.8) cm (p=0.4). The time between the application of cream and the arterial puncture was 60 min.

Although several articles have been published about the analgesic efficacy of the EMLA cream in different surgical procedures and in arterial and venous cannulation,3-5 no contrasted study has used the cream in simple arterial puncture. According to our data, the benefit in this procedure seems doubtful. Moreover, a period of ≥45 min is necessary before the puncture can be performed. For all these reasons, we continue to advocate lidocaine infiltration in the zone of the puncture.

Jordi Giner, RN
Pere Casan, MD
Joaquín Sanchis, MD
Departament de Pneumologia
Hospital de la Santa Creu i de Sant Pau
Barcelona, Spain

REFERENCES

Possible Role of Buspirone Hydrochloride in Smoking Cessation

To the Editor:

Smoking cessation remains a primary objective in the prevention of pulmonary disease. A great number of programs have been developed over the past 30 years to help patients eliminate this habit. The use of transdermal nicotine preparations along with behavior modification provides an effective technique for achieving this goal.1 However, a large number of patients have not found success with this approach. One of the main reasons for this may be the increased anxiety noted by many patients as they undergo withdrawal from cigarette smoking.2,3

Buspirone hydrochloride, a centrally active serotonin uptake modulator, may significantly reduce acute nicotine withdrawal symptoms.4 However, studies using buspirone alone as a pharmacologic treatment in smoking cessation have yielded mixed results.5-7 Thus far, no detailed studies have been performed that evaluate the combined effect of buspirone and transdermal nicotine in smoking cessation. However, we have found that in patients who have failed traditional smoking cessation programs because of anxiety related to nicotine withdrawal, buspirone has been useful when combined with transdermal nicotine preparations. Because the peak anxiolytic effect of buspirone may require 3 weeks of therapy, patients who had failed previous smoking cessation programs because of anxiety were started on a regimen of buspirone for 1 month prior to having them begin transdermal nicotine. Patients were started on a regimen of 10 mg tid, which was titrated up to a maximum of 20 mg tid over a period of 4 weeks, depending on tolerance and need for further anxiety control. During this preliminary period, patients were encouraged to decrease their intake of cigarettes, but they were not prohibited from smoking until they had been on buspirone for 1 month. After 1 month on buspirone, patients were told to stop smoking altogether and to begin a transdermal nicotine preparation, the dose of which depended on the extent of their prior cigarette usage. The dose of the transdermal nicotine was gradually reduced in each patient over a period of 2 to 3 months. Patients were seen on a monthly basis or, if they needed further counseling regarding their symptoms or the use of their medications, more frequently. Liberal telephone support was also provided by the physician.

Over the past 3 years, 23 patients who had failed other smoking cessation programs that did not incorporate anti-anxiety medications have been treated with this program. Nine patients dropped out due to noncompliance, but 12 (52%) successfully completed the program and have remained smoke-free for more than 1 year. Two other patients have had significant reductions in smoking, but have not been able to totally quit. These results compare favorably with other approaches to smoking, which have overall success rates of 20 to 40% at 1 year.8 A number of our patients who have successfully remained off cigarettes continue to periodically rely on buspirone for anxiety control when they are tempted to resume smoking.

Smoking cessation remains a serious problem in preventive health care. No one program is likely to work for all patients, but for those patients in whom anxiety seems to be playing an important role, a program combining buspirone and taping doses of transdermal nicotine may be worthwhile. This may be especially true in patients who have failed other programs. A