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PROSPECT guideline for elective caesarean section: a reply

We thank Dr. Marr [1] for his thorough reading of the PROSPECT guideline for elective caesarean section [2] and for his valuable comments. Dr Marr is correct in stating that the evidence supporting dexamethasone is not strong. However, according to PROSPECT methodology, the use of dexamethasone can be recommended [3]. Indeed, an intervention is recommended if two randomised controlled trials provide evidence of clinically significant improvements in pain scores. Further, the PROSPECT methodology also allows for recommending an intervention if the Working Group deems it appropriate, based on the balance between the positive effects on pain scores and potential side effects. The PROSPECT Working Group concluded that although the evidence for improved pain scores with intravenous (i.v.) dexamethasone is limited, it is clinically significant, and dexamethasone is a relatively safe and easy intervention. An additional benefit is that dexamethasone is a potent anti-emetic with prolonged duration of effect and is considered a critical component of an optimal anti-emetic prophylaxis regimen.

Our discussion section acknowledges the limitations of our methodology as well as the limitations of the included studies [2]. Of note, we can only use the available published evidence for critical analyses. As an example, many interventions are studied where the comparison group received either saline or a placebo, without the administration of basic analgesia such as paracetamol and non-steroidal anti-inflammatory drugs or cyclooxygenase-2 specific inhibitors, which does not reflect current clinical practice, making conclusions challenging.

The study by Shalu et al. [4] had the methodological flaw of not administering basic analgesia. However, the duration of analgesia and the time to receive rescue analgesia were prolonged with i.v. dexamethasone. Further, pain scores for 24 h were clinically and statistically improved with i.v. dexamethasone. Dr Marr is correct that overall opioid consumption was not reduced in the study by Ituk et al. [5]. However, it was reduced in the 6–12-h interval. Additionally, this study also reported improved pain scores, both at rest and movement, at 12 h postoperatively. In fact, i.v. dexamethasone provided improvement in pain scores, although minimal, even with administration of intrathecal morphine. We want to emphasise that no other intervention studied reduced pain scores when intrathecal morphine

was used. Maged et al. [6] showed weak evidence, especially in the local dexamethasone group, for better pain scores and reduced opioid consumption. So basically, we have two positive studies for dexamethasone and one study that displays limited positive effects.

The study by Edomwonyi et al. [7] was not included in our clinical recommendation since the comparator group included tramadol and not placebo.

In essence, we agree with Dr Marr when he states “None of these referenced publications display strong evidence that i.v. dexamethasone should be given to all women having elective caesarean section under spinal anaesthesia in order to improve their analgesia.” Indeed the evidence is limited, but, together with the additional positive effects, the PROSPECT group concluded that it was appropriate to recommend i.v. dexamethasone.

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