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Reply to Snow et al. regarding their comment 'A call to solve the puzzle together by building an evidence base for perioperative management of children with Autism Spectrum Disorder (ASD)

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**Reply to Snow et al regarding their comment 'A call to solve the puzzle together by building an evidence base for perioperative management of children with Autism Spectrum Disorder (ASD).**

Sir, We read with interest your comments (1) about our review article(2) and completely agree. The most significant conclusion from review articles like ours is that little research has been published. There is urgent need for randomized trials and prospective studies. It is difficult to inform clinical care when all we are relying on is case reports.

Arnold et al.(3) reported 39% of children with ASD who had atypical pre-medications, received intramuscular ketamine and 8% had intranasal midazolam i.e. 30% of all children with ASD received intramuscular ketamine or intranasal midazolam or ketamine as premedication for dental procedures. This is regrettable. Using intramuscular ketamine should be reserved for very agitated, aggressive teenagers and only used when all other options failed. Similarly intranasal administration of midazolam causes sting and should be avoided if possible.

It is a matter of urgency to do more randomized trials to identify best practice in this group of children. It is paradoxical, and unacceptable that premedication trials often exclude them. This is the group that most commonly requires premedication. One limiting factor is the commonly used assessment tools. Measuring anxiety using modified Yale Preoperative Anxiety Scale (mYPAS) and emergence agitation using Pediatric Anesthesia Emergence Delirium (PAED) scale are not appropriate or possible as children with ASD may have limited communication as well as reduced eye contact. However, other assessment tools can be used or developed. So indeed we agree: "let's untie our hands and begin the important work of establishing an evidence-base upon which to improve clinical practice"(1)

Ethics: Not Necessary

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1. Snow SL, Smith IM, Bird SJ, Wright SA, Chorney J. A call to solve the puzzle together by building an evidence base for perioperative management of children with autism spectrum disorder. *Paediatric Anaesthesia*. 2016.
2. Taghzadeh N, Davidson A, Williams K, David S. Autism Spectrum Disorder (ASD) and its perioperative management. *Pediatric Anaesthesia*. 2015;25:1076-84.
3. Arnold B, Elliott A, Laohamoonvorapongse D, Hanna J, Norvell D. Autistic children and anesthesia: is their perioperative experience different? *Pediatric Anesthesia*. 2015;25:1103-10.

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