progression to bradycardic arrest with pulselessness and unconsciousness may progress with a rapidity on the order of seconds. Unfortunately, few of the authors of recent studies have addressed the issue of the hemodynamic pattern in the 60–120 s preceding bradycardic arrest/asytole. Even Lesser et al. (8), who published an account of their cases as recorded by automated anesthesia record keepers, did not provide the above information. Granted, this would be difficult without continuous invasive arterial blood pressure monitoring.

The focus needs to shift to detailed analysis of the hemodynamics in the minute or two leading up to bradycardic arrest and asystole during neuraxial anesthesia. This is a time frame more than adequate in which to intervene to prevent calamities.

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In Response:

We would like to thank Drs. Lambert, Pollard, and Stemp for their interest in our recent article (1). It is important to note that the aim of our study was to evaluate the association of preexisting medical conditions and peri-arrest events with survival after cardiac arrest during neuraxial anesthesia. Our series, which includes only the cases of cardiac arrest and does not characterize the progression to bradycardic arrest with pulselessness and unconsciousness may progress with a rapidity on the order of seconds. Unfortunately, few of the authors of recent studies have addressed the issue of the hemodynamic pattern in the 60–120 s preceding bradycardic arrest/asytole. Even Lesser et al. (8), who published an account of their cases as recorded by automated anesthesia record keepers, did not provide the above information. Granted, this would be difficult without continuous invasive arterial blood pressure monitoring.

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