

tem or cardiovascular toxicity. Recovery room stay for these patients was 30–60 min. All patients who had successful blocks (39) stated that the anesthesia experience was not unpleasant and that iv regional anesthesia was preferable to general anesthesia.

DISCUSSION

Numerous reports in the literature attest to the safety and reliability of iv regional anesthesia, although few discuss its application in the lower extremity. Holmes² and Bell *et al.*⁷ mention anesthesia for lower-extremity procedures. Details of their respective techniques, their success rates, and the incidence of complications were not discussed. Recently, Lehman and Jones⁸ reported 58 consecutive patients with fractures or recent injuries of the lower extremity at or below the knee. An arterial thigh tourniquet was used with a dose of 3.3 mg/kg of 0.25% lidocaine. Fifty-one of 58 anesthetics were judged satisfactory, and no serious complications were encountered. The authors did not speculate as to the cause of their failures.

In our report iv lidocaine anesthesia was used for patients undergoing elective podiatric surgery. The calf tourniquet limits surgery to those procedures at or below the ankle and was selected for two reasons: the dose of lidocaine necessary to produce adequate anesthesia (250 mg) would be well within safe range⁹; and a calf tourniquet is more comfortable than a thigh tourniquet. The calf tourniquet appears to be safe as long as it is placed at least 3 inches below the head of the fibula to avoid peroneal nerve compression. Although the double-tourniquet technique for upper-extremity procedures affords excellent patient comfort, its trial on the lower extremity failed. Attempts to use the double tourniquet on the calf resulted in loss of anesthesia while inflating the distal and deflating the proximal tourniquet. We feel that the reason for this is that the normal calf curvature prevented a firm fit of both components of the double tourniquet.

Upon completion of the procedure, the tourniquet was deflated and reinflated several times, in the hope that this

would decrease the incidence of toxic reactions. Kennedy *et al.*¹⁰ reported a very high incidence of toxic phenomena associated with iv lidocaine anesthesia, concluding that continued use of the technique was not justified. In their series, the tourniquet was abruptly deflated at the completion of surgery. Mazze and Dunbar⁵ also abruptly deflated the tourniquet, encountering few toxic reactions. These conflicting results are difficult to interpret, but they may be related to different techniques in patient monitoring.

In conclusion, a technique of iv lidocaine anesthesia for surgery at or below the ankle is described and is well suited for procedures lasting 1 h or less. The technique is especially useful for outpatient surgical procedures. Small doses of fentanyl and diazepam add to the patients' comfort and still allow for relatively short recovery room stays. The technique appears to be reliable, safe, and well accepted by surgeons and patients.

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Erratum

In the article "Bicitra® (Sodium Citrate) and Metoclopramide in Outpatient Anesthesia for Prophylaxis against Aspiration Pneumonitis," by L. Manchikanti, J. B. Grow, J. A. Colliver, C. H. Hadley, and L. J. Hohlbein (ANESTHESIOLOGY 63:378–384), in the abstract, eighth line from the end, the correct Group in parentheses should be Group 4, not Group 6.