

However, we are not clear how this case report should change our future practice. The author's opening statement that "Nerve injury is *awell*-recognized complication [italics our own] of peripheral nerve blocks" is misleading in that it implies that nerve injury related to regional anesthesia is a common occurrence. Large series have already shown that neurologic deficits after peripheral nerve block are mostly transient and, overall, very uncommon.² Even neurologic complications specific to continuous catheter techniques are reported as infrequent.³ The etiology of neurologic complications is polyfactorial, and there are multiple possible causes of neurologic deficit after surgery, most of which are more common than those related to the regional anesthetic technique.^{4,5} Even in this case, with the evidence from the investigations conducted, it is not absolutely certain that the tourniquet was not at least partly responsible for the nerve injury.

This case does, however, highlight the complications associated with subclinical neuropathy. These are probably more common than appreciated, given the high incidence of diabetes (and other causes of neuropathy) in our clinical workload. The preoperative diagnoses of a subclinical neuropathy may not be possible unless specific preoperative investigations are directed toward this etiology. Further, there may be an overall increased susceptibility to the other etiologies of nerve injury.⁶⁻⁸ Whether the finding of this risk factor will lead to fewer patients being offered regional anesthesia (and/or tourniquets) is speculative and open to further discussion. Nonetheless, the results of this case further reinforce the fact that in the unfortunate event of a postoperative neurologic deficit, the findings of preexisting subclinical neuropathy could become important. Advocacy of regional anesthesia and careful discussion of its benefits (balanced by its risks) should begin preoperatively and continue even in the event of an adverse outcome or complication. We believe that the benefits of peripheral nerve blocks are significant and the risks, although present, are very

low and that regional anesthesia should be offered to all suitable patients.

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In Reply:—We thank Drs. Eipe, McCartney, and Kummer for their interest in our case report regarding preexisting subclinical neuropathy as a risk factor for nerve injury after continuous ropivacaine administration through a femoral catheter.¹

We did not intend to promote guidelines to change regional anesthesia daily practice with this case report. The modest aim was to make anesthesiologists aware of the possibility to evidence the presence of preexisting subclinical neuropathy even after new nerve damage has occurred.

The term "well-recognized complication" has been misunderstood by Eipe *et al.* This is a semantic question. "Well-recognized," according to the work of Selander and others,^{2,3} means that in certain conditions, the needle and local anesthetics can damage the nerve. This is a well-recognized reality. This statement has nothing to do with incidence. We completely agree with Eipe *et al.* that nerve injury related to regional anesthesia is a very rare occurrence.^{4,5} It seems that improved needle design, new safer approaches, and better technical application of block performance help to steadily decrease the incidence of this problem.

We cannot absolutely exclude the responsibility of the tourniquet, but its implication in this case seems very unlikely because tourniquet-induced nerve damage is almost always a conduction block which can be precisely localized by the means of somatosensory evoked potentials.^{6,7} In this case, we had signs of nerve denervation not localized at the site of tourniquet application.

We want to emphasize once more the importance of early postoperative neurophysiologic examination in case of occurrence of new neurologic deficits. This helps to prove or rule out a preexisting and undiagnosed neuropathy, which might have important medicolegal

issues. Finally, we completely agree with Eipe *et al.* that good practice of regional anesthesia begins preoperatively and continues long after completion of surgery.

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