Subomohyoid–Suprascapular *versus* Interscalene Block: Comment

To the Editor:

While we welcome research into regional anesthesia in order to improve the quality of our medical provision, the study by Abdallah *et al.* demonstrates highly relevant problems in research in this area.[1] First, the authors describe the interscalene block as one that poses dangers to certain populations. This may be true for a minority of patients such as those with severe respiratory impairment, but the vast majority of patients are not restricted by any ensuing respiratory compromise. Studies of healthy patients demonstrate that the phrenic nerve palsy is of no clinical relevance.[2] Given that 2.5 yr in three hospitals were required to obtain the 136 patients in this study, there does not appear to be a large group of patients likely to benefit from a new block.

It has to be realized that regional anesthesia provision remains far from universal. Although the interscalene technique has been around for many years and refined with the use of ultrasound, a recent Canadian study demonstrated that only around half of shoulder surgery patients were receiving a nerve block for ambulatory surgery.[3] This is likely much lower in many other health systems. One of the reasons for this is likely a lack of training and confidence of anesthesia providers in performing the block; lack of resources also contributes. Refining blocks further, and in effect making them more difficult, is unlikely to benefit the population as a whole. It needs to become a more significant priority in the provision of regional anesthesia that basic blocks are able to be performed competently by more anesthesiologists rather than the ever increasing number of new blocks with small, unclear benefits.

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Competing Interests

The authors declare no competing interests.

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This letter was sent to the author of the original article referenced above, who declined to respond.—Evan D. Kharasch, M.D., Ph.D., Editor-in-Chief.

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Sparking the Discussion about Vaping and Anesthesia: Comment

To the Editor:

I agree with Drs. Feinstein and Katz that little is known about perioperative vaping.[1] The authors refer to an outbreak of 53 cases of e-cigarette and vaping–related lung injury, in which 84% of the cases admitted to the use of tetrahydrocannabinol products. The remaining 16% may have concealed the use of an illegal product, or not known what they were using. In those cases of e-cigarette and vaping–related lung injury where bronchoalveolar lavage was performed, 100% of the specimens were positive for vitamin E acetate, a dangerous contaminant in tetrahydrocannabinol oil.[2] This outbreak is troubling but it is unrelated to the use of legal nicotine-based vaping products.

They also refer to a letter that raises the hypothetical possibility that an anxious preoperative patient might vape