We respectfully disagree with their assertion and would like to offer the following explanation to substantiate our claims.

Their article described the sono-anatomy of the sciatic nerve and a technique of performing ultrasound-guided sciatic nerve injection at the infra-gluteal location in volunteers. By definition, ‘infra-gluteal’ is inferior to the gluteal crease. Therefore, an infra-gluteal injection for sciatic nerve block is performed inferior to a line joining the greater trochanter and the ischial tuberosity. Figure 1 in their article illustrates the location at which the infra-gluteal ultrasound scan and injection is performed. In the technique that we describe, the ultrasound scan and needle insertion is performed above the gluteal crease and directly over a line joining the lateral prominence of the greater trochanter and the ischial tuberosity. Although the two techniques may appear similar, because they are both ‘sub-gluteal’ injections, that is, under the gluteus maximus, and both injections are made in relation to the greater trochanter and the ischial tuberosity, there are subtle anatomical differences that make these two techniques different.

In the technique that we describe, the ‘sub-gluteal space’, which is a well-defined anatomical space and contains the sciatic nerve, is initially identified on the ultrasound image as a hypo-echoic area between the hyper-echoic perimysium of the gluteus maximus and the quadratus femoris muscle. Distention of the subgluteal space to a test injection of saline through the block needle is then confirmed—‘our end point’, irrespective of whether a motor response to nerve stimulation is elicited in the foot or not, before the local anaesthetic is injected. In contrast, Chan and colleagues perform their ultrasound-guided subgluteal injection in the infra-gluteal position after identifying the sciatic nerve using nerve stimulation. There is no mention by Chan and colleagues as to whether they were able to identity a potential perineural space on the ultrasound image of the infra-gluteal area before the local anaesthetic injection, although they report enlargement of the space after the injection. We were able to identify pulsations of the inferior gluteal artery medial to the sciatic nerve in the ‘subgluteal space’ whereas Chan and colleagues were unable to identify any blood vessel in the vicinity of their injection confirming that our two techniques were performed at different locations. Moreover, local anaesthetic also spreads between different muscles in the two techniques. In our technique, the local anaesthetic spread between the gluteus maximus and the quadratus femoris muscle. In comparison, in the infra-gluteal technique, it spreads between the gluteus maximus and biceps femoris muscle posteriorly and the adductor magnus muscle anteriorly.

We agree that the above discussion should have been included in our report and hope that it will help clarify the differences between our technique and the technique of ultrasound-guided subgluteal sciatic nerve block at the infra-gluteal position.

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Use of LMA-ProSeal™ drain tube for esophageal instrumentation

Editor—The LMA-ProSeal™ has extended the range of surgical procedures that may be undertaken without tracheal intubation. A recent case illustrated that this repertoire may be further extended to include investigative and potentially therapeutic procedures of the upper alimentary tract.

A 73-yr-old man, who had previously undergone radical radiotherapy and chemotherapy for invasive post-cricoid squamous cell carcinoma, re-presented with dysphagia caused by a cricopharyngeal stricture. Despite endoscopic dilatation of the stricture, insertion of a nasogastric tube was unsuccessful and a percutaneous endoscopic gastrostomy (PEG) was indicated for enteral feeding. The patient underwent a general anaesthetic and before commencing an open PEG procedure, the decision was taken to attempt a direct PEG procedure using the drainage tube of the LMA-ProSeal™, which is designed to lie at the upper oesophageal sphincter, as access for the endoscope. The internal diameter of the drain tube of size 3 and 4 LMA-Proseal™ is 6.5 (0.22) mm. Initially, a size 5 LMA-Proseal™ was inserted, using the recommended digital insertion technique, but was exchanged for a size 4 LMA-Proseal™, as it was felt that the radiotherapy may have altered the dimensions of the oro-pharynx. Although ventilation continued through the airway tube, a lubricated fibre-optic laryngoscope (FOL) (11302BD1, Karl Storz
Endoskope, Germany), with an outer diameter of 3.7 mm and length of 65 cm was inserted through the drain tube of the size 4 LMA-ProSeal™ and successfully passed under direct vision through the cricopharyngeal stricture into the oesophagus and stomach. Unfortunately, the FOL was used was of insufficient length to adequately transilluminate the stomach and ultimately the gastrostomy tube was inserted via a mini-laparotomy, with ongoing ventilation via the LMA-ProSeal™. A paediatric endoscope with a greater length than the FOL was not immediately available at this site but may have allowed successful completion of the PEG insertion.

This case illustrates that the drain tube of the LMA-ProSeal™ may be used for oesophago-gastric instrumentation. The LMA-ProSeal™ has already been demonstrated to be a safe alternative to nasal cannulae in a paediatric population undergoing gastroscopy. This technique allows the LMA-ProSeal™ to be compatible with small diameter devices for oesophagogastroduodenoscopy, transoesophageal echocardiography, and oesophageal Doppler cardiac output monitoring.

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Levosimendan in septic shock: a case series

Editor—Leverosimendan, a novel calcium sensitizer and K-ATP channel opener, has been used in a variety of clinical settings, including acute decompensated and low output heart failure, adult respiratory distress syndrome, ischaemic myocardial stunning, and cardiac surgery. We would like to report our use of levosimendan (0.1–0.2 μg kg⁻¹ min⁻¹) over 24 h as rescue therapy in six patients with refractory septic shock, despite conventional resuscitation. Cardio-respiratory, metabolic, and outcome data were collected and reviewed.

In this group of patients, post-levosimendan infusion, there was a trend towards increased mean arterial pressure, improved arterial oxygen partial pressure: fractional inspired oxygen ratio, increased cardiac index, reduced base excess, improved pH, and reduced lactate. There was also a reduction in heart rate, pulmonary vascular resistance index, and systemic vascular resistance index. Catecholamine requirements were reduced in all patients. There were no adverse effects associated with the use of levosimendan in this group and despite predicted 28 day mortality by APACHE II score being approximately 60%, all but one of the patients survived to leave hospital.

There are data emerging to support the use of levosimendan in septic myocardial depression and its role in reducing the incidence of ARDS in sepsis. There are also data from experimental models that levosimendan may have a protective role in endotoxaemic acute renal failure and an immuno-modulatory effect via pro-inflammatory cytokine level reduction.

Our series of septic shock patients treated with levosimendan differs from previous series, in that its use as rescue therapy was not limited to those with previously normal left ventricular function or to those in whom dobutamine had been ineffective. We did not limit our use of levosimendan to those with low output cardiac states, but rather we used it as rescue therapy in those whose catecholamine requirements remained high, despite adequate fluid resuscitation.

Our observations appear to support the growing interest in the use of levosimendan in septic shock as a safe and potentially useful adjunct to conventional therapy. We are currently undertaking a prospective, randomized, placebo-controlled trial to further investigate the use of levosimendan as rescue therapy in refractory septic shock as an adjunct to conventional therapy.

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