provides improved analgesia in a number of settings. Their citation list is impressive, and I would note that systemic betamethasone has also shown promise. Regarding their concerns about neurotoxicity, I agree that it is an unsettled issue. We made no assertions about the safety or recommendations for the use of perineural dexamethasone. One must not, however, be alarmist: a careful reading of one of their citations, an elegant preclinical model of adjuvant neurotoxicity, reveals that, in the paradigm studied, ropivacaine was much more neurotoxic than dexamethasone.

One larger question I would like to pose is, ‘What is the duration of a nerve block?’ Is it the duration of anaesthesia to pinprick? Is it the duration of motor weakness? Or, as I would argue, is it the length of time the patient is comfortable? In a real-world setting, we studied the most easily measured and clinically relevant outcome: how long patients were comfortable enough to not require other analgesics.

Yes, systemic administration, if equally effective, would be much preferred. Including systemic administration in our trial would have required a much larger patient sample, as it was already a four-group trial. Consequently, we were forced to leave the question open. It will not, however, remain open for long.

Declaration of interest
None declared.

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Ultrasound-guided supraclavicular approach to the subclavian vein in infants and children

Editor—We read with interest the article describing the new method for ultrasound-guided supraclavicular approach to the brachiocephalic vein in children. We routinely cannulate the subclavian vein by a supraclavicular approach under ultrasound guidance in children undergoing surgery for congenital cardiac defects. In our series of 150 children, the right subclavian was accessed in 140 and the left side was used in 10 patients. The age range was 12 days to 14 yr and weight ranged from 2.7 to 35 kg. There were two (1.33%) arterial punctures with one (0.67%) periarterial haematoma, one (0.67%) pneumothorax, two (1.33%) malpositions into the opposite innominate vein and we were not able to cannulate on two (1.33%) instances.

We agree with the authors on the following points:

(i) During the time course of the study, there is an improvement in the puncture success rate.
(ii) Ultrasound images of the brachiocephalic vein and subclavian vein were easily visualized using the supraclavicular approach.

Our technique is different from that described in the following aspects:

(i) The operators stood at the head end rather than by the side of the patients and as all of them were right handed, 93.5% were placed in the right supraclavicular vein.
(ii) We use an open-ended ethylene oxide sterilized plastic sheath for sterile handling of the ultrasound probe. Once the probe emerges out of the sheath, it is covered with sterile Tegaderm (transparent medical dressing), ensuring that no air bubbles are entrapped. No gel is used in between the probe and Tegaderm.
(iii) We use a few drops of sterile saline as coupling gel. The quality of images was similar to when agent was used.

The authors have not mentioned the length of the cannula inserted and the incidence of unintentional decannulation on the right side. This is important as the right brachiocephalic vein is very close to the superior vena cava–right atrium junction in very small babies. The authors have also not mentioned the incidence of damage to the thoracic duct while cannulating the left brachiocephalic vein.

Declaration of interest
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