<table>
<thead>
<tr>
<th>Study</th>
<th>Medication</th>
<th>Dose of adjuvant</th>
<th>Site</th>
<th>Sensory block</th>
<th>Side-effects</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malenfant Rancourt MP, Albert NT, Coˆt´e M, Le´tourneau D-R, D.-R. Le´tourneau</td>
<td>3 ml ropivacaine 0.75%</td>
<td>20 µg dexmedetomidine</td>
<td>Ulnar nerve (volunteers)</td>
<td>350 (± 54) min ropivacaine</td>
<td>No haemodynamic variations</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Posterior tibial nerve</td>
<td>only (5.8 h) vs 555 (118) min ropivacaine + dexmedetomidine (9.25 h)</td>
<td>Noticeable decrease in blood pressure and lowered heart rate in certain volunteers</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>972 (± 120) min ropivacaine only (16.2 h) vs 1290 (± 72) min ropivacaine + dexmedetomidine (21.5 h)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

We will remain interested in further publications on this subject as this will deepen our understanding of the pharmacology of this drug leading us to a fruitful and efficient use of dexmedetomidine in regional anaesthesia possibly providing significant advantages for our patients.

**Declaration of interest**

None declared.

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**Dexmedetomidine as adjuvant for peripheral nerve blocks**

**Reply from the authors**

Editor—Dr Albert has compared our results with their own data, both recently published. This is indeed very interesting, as the duration of ulnar nerve block and posterior tibial nerve block differ considerably. As acknowledged by Dr Albert, the methods of nerve block differ in the doses of ropivacaine (22.5 vs 50 mg) and of dexmedetomidine (20 vs 50–70 µg). In their study, Malenfant Rancourt and colleagues report much longer block duration compared with our data, and discuss how measurement of sensory block may explain differences.

However, both studies are volunteer studies, and the measurement of sensory block is the main outcome. When it comes to daily clinical practice, the duration of sensory block is not the outcome we wish to know. It is the time until the patient feels pain and demands an analgesic. From our volunteer data, it seems that this time may be prolonged by dexmedetomidine. From our point of view, dexmedetomidine is the most promising adjuvant we ever tested. What we need now are dose finding studies, and safety data for peripheral nerve blocks. As dexmedetomidine seem to have central effects dose finding studies need to be designed thoughtfully. The safety data in rats seem very promising. We believe that dexmedetomidine will improve peripheral nerve blocks substantially, although it is far too early to conclude this from the existing data.

**Alternative methods to improve probability of CVC catheter placement**

Editor—We read with interest the review article on central venous catheters (CVC) in which the routine use of ultrasound (US), manometry (needle and catheter), pressure waveform analysis, blood gas analysis, image intensifier, and ECG guidance are recommended to prevent misplacement. However, some if not all such equipment may be unavailable in theatres or in the Emergency Department, where CVC catheters often need to be inserted as a matter of urgency. We would, therefore, like to highlight other cheaper methods which may ensure correct CVC tip placement.

Initially directing the tip of the J wire caudally before insertion has been shown to significantly increase the probability of correct placement of CVC catheter in the superior vena cava or right atrium (97 vs 56%).

**Declaration of interest**

None declared.