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.

Declaration of interest

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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%).
During right subclavian CVC insertion, ipsilateral head turning and supraclavicular pressure reduced the risk of inadvertent internal jugular vein (IJV) cannulation from 9.1 to 3.6%. Although this difference was not statistically significant, the manoeuvre may reduce the size of the IJV lumen and so decrease the risk of the guide wire travelling up the IJV.

Ambesh and colleagues found that manual compression of the IJV resulted in a clear increase in transduced pressure if the catheter tip was misplaced into the IJV. While this was useful in identifying accidental IJV cannulation, they subsequently showed that manually occluding the IJV in the supraclavicular region successfully prevented the passage of the guide wire into the IJV.

Although such techniques decrease the risk of misplaced CVC catheter, they do not eliminate it altogether. Sound clinical judgement and radiological assessment are still necessary to confirm correct placement of central venous catheter.

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None declared.

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Alternative methods to improve the probability of correct central venous catheter placement

Reply from the authors

Editor—We thank Dr Gan and Dr Lanigan for their interest in our article. They are correct in citing a number of ways to improve the success of passing catheters and guidewires into the central veins. We did not cover this in detail as space precluded it and many other elements of central venous catheterization. The thrust of our article was to highlight applied anatomy of the superior vena cava and central veins, and catheter malposition in relation to normal and abnormal anatomy, which we believe is not that well covered in anaesthesia and critical care texts. Guidance is given to aid recognition and management of misplacements rather than all the techniques to prevent them in the first place. No one technique, or combination, used to minimize catheter misplacement is 100% effective and the ability to identify and manage misplaced catheters remains one key element of safe practice.

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Control group bias: a potential cause of over-estimating the benefit of videolaryngoscopy on laryngeal view

Editor—The adoption of videolaryngoscopes (VL) into everyday anaesthetic practice is rapidly increasing, however much of the evidence supporting their benefit lacks scientific rigour.

Despite other proposed advantages their prime role is to facilitate intubation by improving the view at laryngoscopy.

Studies investigating the efficacy of VLs in improving laryngeal view ideally compare the laryngeal view during videolaryngoscopy with that achieved with direct laryngoscopy (DL), with the best studies comparing laryngeal view during DL. However, even these studies are potentially prone to bias because of inability to blind the intubator and the possibility of intra-observer variability in grading laryngeal view. If such bias exists, it would likely lead to higher than expected rates of ‘difficult laryngoscopy’ in the control (DL) group of such studies. This bias would have two effects: first it would overstate the likely benefit of VL in individual cases and secondly it would artificially increase the power of such studies to show benefit.

We used published reports (summed where necessary) to identify expected frequencies of Cormack and Lehane (C&L) grade ≥3 during DL for (A) unselected populations, (B) patients whose necks were immobilized with manual in line stabilization (MILS), (C) patients immobilized with a stiff neck collar, and (D) patients with a Mallampati class ≥3. For each group, we identified (or calculated) an overall expected frequency of C&L ≥3 including a point estimate and 95% confidence interval (CI). For Group D after discussion with the author of the paper we used the most conservative estimate of the upper confidence level.

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