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Do continuous ‘lumbar plexus’ blocks really increase the risk of falls?

Editor—I read with interest the recent review published by Johnson and colleagues1 on falls after major orthopaedic surgery. The authors should be congratulated for demonstrating that the frequency of falls in orthopaedic patients benefiting from continuous ‘lumbar plexus blocks’ was similar to the frequency of falls observed in surgical patients. This conclusion was based on an analysis of more than 4000 patients. Their data confirm our previously published findings from a data analysis of falls from our own hospital.2 Even though the authors were extremely careful in the choices they made, and discussed a number of limitations for their analysis, they failed to acknowledge several selection biases.

It is surprising that the study by Williams and colleagues3 was included as a randomized trial when the report on falls from this study was published later as a letter to the editor4 and not reported as an endpoint in the method section of the original paper.5 This contrasts with the obvious assumption that if a study was published, even if the stated goal was to assess complications, if falls was not a key word, it meant that falls was not included as an endpoint rather than a non-event.2

The frequency of falls has been reported to be directly related to a number of pre-, peri-, and postoperative factors including preoperative history of falls,5 advanced age,2 and mobilization without supervision.2 Since none of the studies included in this analysis was controlled for these factors it is possible to conclude that the difference among the groups was related to the presence or absence of blocks and not due to a difference in the patient distribution in terms of preoperative history of falls, the number of elderly and very elderly patients, or the number of patients who walked without supervision.3

A fall is an established complication of joint replacement. In these conditions, it is surprising that Johnson and colleagues1 included cohort studies related to blocks in their analysis but did not include studies not involving blocks. This would certainly provide a more balanced evaluation.6 It is also surprising that the authors did not include the Ackerman and colleagues’ study5 as one of their cohort studies, since the study included 6912 patients with and without blocks.

In conclusion, there is no doubt that a large randomized prospective study focusing on falls would greatly help in determining the role that nerve blocks may play in falls after joint replacement. However, in the current trend including the use of low concentration, low volume of local anaesthetics, it is uncertain that ‘lumbar plexus’ blocks really affect quadriceps function in patients undergoing total knee replacement, since it is established that the surgery itself reduces quadriceps function by 60%.7

Declaration of interest

None declared.

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Use of the i-gel in unexpected difficult airway

Editor—We support the findings as reported by Theiler and colleagues. We believe that the i-gel is a helpful device in unexpected difficult airways, providing ventilation during cricothyrotomy if the larynx is not visible. If the larynx is visible and intubation is possible, the i-gel also gives a short period of ventilation during guidewire insertion. As the i-gel is designed to fit a range of face shapes, it provides a larger surface area for ventilation than the i-larynx, which may be helpful in an unexpected emergency.

The i-gel has not been formally compared with the i-larynx in its clinical use. However, two case reports have described the use of the i-gel in patients with difficult airways, with successful ventilation achieved. One case report describes the i-gel being used in a patient with a difficult airway due to a history of previous thyroid surgery. The other case report describes the i-gel being used in a patient with a difficult airway due to a history of previous neck surgery.

In conclusion, we believe that the i-gel is a useful device in unexpected difficult airways, providing ventilation during cricothyrotomy if the larynx is not visible. If the larynx is visible and intubation is possible, the i-gel also gives a short period of ventilation during guidewire insertion. As the i-gel is designed to fit a range of face shapes, it provides a larger surface area for ventilation than the i-larynx, which may be helpful in an unexpected emergency.

None declared.

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