intrafascicular spread, but no evidence of infiltration into the spinal cord. Moreover, in a comparative retrospective analysis of 5436 peripheral nerve blocks steered either by surface landmarks or by ultrasound enhancement, Orebaugh and colleagues found significantly fewer adverse outcomes associated with the ultrasound-guided interventions.

Unfortunately, the description of current case report fails to note patient habitus, use of auxiliary equipment (nerve stimulation or ultrasound), and clinical interpretation of the post-positioning haemodynamic instability (such as Bezold–Jarisch reflex). The combination of an increased neck girth, general anaesthesia, and absent ultrasound-guidance increases the likelihood of needle misadventure. Real-time ultrasound identification of the needle tip and pattern of LA spread should reduce the incidence of this catastrophic complication.

**Declaration of interest**

None declared.

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**Journal club response**

Editor—We read the recent article on the use of propofol by emergency department (ED) physicians, written by Drs Lloyd, Newstead, and colleagues, with great interest and also had the article presented in our departmental journal club meeting. This study, as correctly mentioned by the authors, adds to the already existing data on procedural sedation in the ED. We would however like to raise certain points which were highlighted in our meeting and we felt that they should be communicated back to the authors. We could not see any clear sedation endpoints which were set to guide the doctors using propofol for sedation and were not sure if different doses or endpoints were being used for different procedures being carried out in the ED. We felt that this was important since some procedures were potentially more stimulating than others and hence the dose required for those would be different. The online Supplementary material suggests that the procedure should be carried out when the patient is ‘unconscious, i.e. not responding to command’ which surely constitutes an anaesthetic rather than sedation. To add weight to this, the online supplement refers to a propofol anaesthetic, not propofol sedation. It seems that the vast majority of the patients were probably being anaesthetized rather than sedated and this may well explain why the incidence of hypoxia in this study was similar to those reported for non-cardiac anaesthesia. In addition, seven of the patients received concurrent i.v. morphine. Despite this, there was no reduction in the dose of propofol given. In the discussion regarding the 11 sentinel cases, it is stated that two elderly patients were given above the recommended amounts of propofol. The definition of elderly was not described but assuming this was >75 yr, all six elderly patients were given an initial bolus above 0.5 mg kg\(^{-1}\). In addition, all patients who received incremental top ups received them above the 0.25 mg kg\(^{-1}\) guideline dose. In total, nine cases received doses above those recommended in the guideline. Finally, Cases 3 and 11 clearly did meet the criteria for a sentinel event before sedation as they were patients who were very unstable; surely having an anaesthetist present to sedate these patients would have been essential in the safe management of these patients.

**Declaration of interest**

None declared.

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**Procedural sedation: it is not what you do, it is how you do it**

Editor—We read with interest the recent report on the use of propofol for procedural sedation in the emergency department (ED) by Newstead and colleagues. We applaud the authors for their use of a standardized reporting tool and the transparent discussion of the encountered adverse events and would like