

caused by tumor and in the other, chronic obstructive pulmonary disease [COPD] with hyperinflation of the lungs). Dr. Moore's contention that we were "minimaxing" by not concluding that CT is optimal for NCPB implies that we were trying to minimize our opponent's gain and maximize our own. For this, we must be opponents, but we are on the same side. We too think that CT can be very useful during NCPB. But, until there is more scientific evidence, we still choose to waffle about the superiority of CT over plain roentgenography.

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What Kind of Anesthesia You Will Choose for Yourself if You Are a Patient: Regional Anesthesia or General Anesthesia?

To the Editor:

This question was sent by E-mail to 665 anesthesiologists in 60 countries on May 18, 1997. A total of 45 E-mails were returned undelivered, and 72 responded (11.61%).

A total of 79.16% of them chose regional anesthesia, while only 20.83% chose general anesthesia. This global study is in accordance with the previous American studies, which found that 68% of the anesthesiologists in 1973 preferred regional anesthesia over general anesthesia¹ and 74% in 1986.²

If the situation is that most of the anesthesiologists prefer regional anesthesia for themselves, why are there are so many procedures done under general anesthesia on nonanesthesiologist patients?

I have already asked this question twice before, and it remained unanswered until now.³⁻⁴

Enclosed are selected remarks written by some of the anesthesiologists who participated in this survey.

1. To be totally honest I would choose a combination of both, but if pushed I guess a local/regional with sedation (I am a real coward).
2. It really depends. . . on what procedure you propose: e.g., CABG - general, carpal tunnel - local, hernia repair - field block, knee replacement - spinal, hip replacement - general, radical retropubic prostatectomy - general anesthesia with epidural for post op pain. So that is the long answer. . . I think the question is stupid. . . because you cannot answer it without knowing the type of surgery!
3. Your question is too broad. A mixture of regional and general is optimal - also depends on the type of procedure: CABG vs vasectomy!
4. Depends by whom, and for what!
5. Your question is far too vague. I would not have CABG under regional, but I might have a hip replacement.
6. My response: "that depends."
7. Thank you for the informations. For what concern your question. . . no doubt!!! REGIONAL (where feasible)!
8. It depends on the type of operation, but whenever possible, I would prefer a regional anesthesia for myself.
9. I will prefer regional anesthesia wherever there is a choice. . .
10. My answer: I have clearly done it! I have undergone an operation on my trimalleolar fracture. I have selected spinal anesthesia. I have selected general anesthesia removing metal equipments.
11. I prefer regional with sedation. Regional is chosen for the additional sympathectomy and the possibility of reducing pain postoperatively; sedation is appreciated as I am as anxious as everyone else.
12. General, but you should suggest different operations.
13. Whether I had general or regional anaesthesia would depend on the operation, for a tonsillectomy I'd have a GA, for an orthopedic procedure on a limb, regional.
14. At my age. . . 40 years. . . I would choose regional.
15. It would largely depend on the nature of the surgery, but for the lower half of the body I would probably opt for regional.
16. Regional !!!!!!!

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Neurotoxicity of Spinal Procaine—A Caution

To the Editor:

The well-designed study of Hodgson et al.¹ showed that procaine has a significantly decreased incidence of transient neurologic symptoms (TNS), but a lower overall quality of anesthesia. It is plausible that TNS represents a reversible neurotoxicity,² and there is a concern that some might use this study as an indication that procaine is also less neurotoxic than lidocaine in terms of causing the far more serious cauda equina syndrome (CES). The authors themselves do not advocate this view, and have pointed out elsewhere that risk factors for CES and TNS do not always correlate; e.g., in terms of concentration dependence.³ Their conclusion that "further evaluation is required before procaine can be recommended as a suitable alternative" to "lidocaine as a short-acting local anesthetic suitable for outpatient spinal anesthesia"¹ is supported by 2 much earlier reports that are not electronically indexed and may not be known to many readers of the report of Hodgson et al.¹ While these studies reflect much earlier clinical practice and do not provide all the information we would like, nevertheless they are relevant to the question of procaine neurotoxicity.

Ferguson and Watkins⁴ reported in 1937 a series of 14 cases of CES after single-injection spinal anesthesia with heavy 10% procaine, with an incidence of ~1% in their practice over a period of 20 months. Causes other than procaine neurotoxicity, such as needle trauma, were excluded as much as possible given the techniques then available. The dose of procaine administered was not specified, and the procaine was in a formulation ("duracaine") which contained up to 10% glycerin, trace amounts of gliadin or gum acacia, and 15% ethanol. No cases of CES were observed during the same period with a similar number of amylocaine and dibucaine spinal anesthetics, although minimal information is given on those anesthetics.

While it is tempting to ascribe these cases of CES to the ethanol⁵ or other additives rather than the procaine, an accompanying laboratory study⁶ suggested that procaine itself was the neurotoxic agent. Cats were administered 0.5 mL subarachnoid injections at L6-7 (5 times the authors' usual clinical dose on a weight basis), with a resultant block that was below the level of the forelimb tendon-jerks and phrenic nerve. Glycerin 20% in 15% ethanol did not produce any toxicity. The clinical "duracaine" preparation of procaine caused lumbosacral paralysis in 56% of 23 animals. Solutions of 10% procaine alone (without additives) caused lumbosacral paralysis in 33% of 33 animals. Procaine alone at 2.5% caused no toxicity, while 5% alone caused paralysis in 10% of 20 animals.

This information supports the call of Hodgson et al.¹ for further research before procaine is adopted as a widespread substitute for lidocaine.

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Suprascapular Nerve Block by a New Anterior Approach for Perioperative Analgesia During Major Scapular Surgery in Two Patients

To the Editor:

We would like to report a new anterior approach of a suprascapular nerve block for perioperative analgesia during major scapular surgery. Suprascapular nerve block is frequently performed for the treatment of chronic shoulder pain of different etiologies,¹⁻³ but its use is also reported for analgesia after scapular fracture⁴ and for postoperative analgesia in arthroscopic shoulder surgery.⁵ This block is usually performed using a standard posterior technique in the supraspinatus fossa firstly described by Wertheim and Rovenstine⁶ in 1941, but a more proximal approach has also been mentioned.³

We simulated an interscalene block with a slightly posterolateral direction of the needle in 2 young American Society of Anesthesiology (ASA) I and II patients scheduled for extensive scapular surgery under general anesthesia. The needle was directed at a narrower angle (30°), thus the direction of the needle was more lateral and posterior than in the classical interscalene approach