Sir,

We thank the readers for taking keen interest in our study and raising a few safety issues, which need clarification. The rationale for using ProSeal laryngeal mask airway (PLMA: Intravent Orthofix, Maidenhead, UK) in the prone position was not only the accidental extubation in prone position, but the fact that if a technique (PLMA insertion in prone position) has been described for an emergency situation, the same can be used in a controlled elective scenario. Ours is not the first report of the use of PLMA in the prone position. There are several reports of PLMA use in prone position in adults for elective as well as emergency procedures. This technique allows the patient to lie at ease in a position where he/she is most comfortable. Our aim was to see if PLMA insertion in the prone position can reduce the time to surgical readiness and the number of personnel required to position these patients prone.

We fully agree that adequate planning and vigilance are cornerstones for prevention of any mishap and ensuring a successful outcome. Some anesthesiologists may never encounter any case of inadvertent extubation of the endotracheal tube in the prone position, but there is no denying of the fact that it does occur. The Fourth National Audit Project of the Royal College of Anesthetists mentions the increased use of the supraglottic airway devices as a primary airway management device for general anesthesia. Any new technique or piece of equipment gradually gains acceptance and with time its scope of applications broadens. Anesthesiologists experienced in the use of PLMA are comfortable using it in different clinical scenarios.

We followed all the standard patient safety precautions in the proper prone positioning. There was no abdominal compression and no hyper-abduction of the arms. Adequate padding to the pressure points was provided as mentioned in the manuscript. The image seen in the photographs is the position taken by the patient himself, and the arms were kept above the head with the elbows flexed and supported. The picture describing the insertion technique was taken from the head end and therefore, it did not show free abdomen, which can be seen only in a side view. If one looks carefully, side arm boards can be seen.

We defined the surgical readiness time from induction of anesthesia till the patient was finally positioned and handed over to the surgeon. Hence, the starting point as well as the end point were the same in both groups.

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In response to: Comparison of paravertebral and interpleural block in patients undergoing modified radical mastectomy

Sir,

We have gone through the above mentioned clinical study by Kundra et al. with great interest. It has potentiality to enrich the knowledge about role of regional anesthesia/analgesia in cancer surgical patients. Recently, it has been found that paravertebral block (PVB) in comparison to general anesthesia can reduce cytokine response of breast cancer surgery. Use of sole regional anesthesia technique may even reduce the chance of cancer recurrence.

However, we would like to comment about few issues here:

Firstly, the authors did not mention whether any procedure related complications had occurred in any of the study group patients. Both of these techniques can give rise to pneumothorax, which at times may of clinical significance. Horner syndrome has also been reported with PVB. The reported incidence of complications of PVB as follows: Hypotension: 4.6%; vascular puncture: 3.8%; pleural puncture: 1.1%; pneumothorax: 0.5%. Bronchospasm has been reported after interpleural analgesia also.

Secondly, the authors have opined that interpleural block may be ineffective in providing analgesia during axillary lymph node dissection. But whether there were hemodynamic responses in patients belonging to inter pleural blocks group during axillary dissection? Time of requirement of intra-operative fentanyl can also be helpful in this regard.

Thirdly, use of postoperative patient-controlled analgesia would have reflected opioid consumption more accurately. Moreover, the study may not be adequately powered to detect any difference in postoperative opioid consumption also. The authors have estimated sample size of the study by the difference in quality of block and they defined “failed block” on the basis of fentanyl requirement intra-operatively, morphine during first 4 h postoperatively and diclofenac (before the scheduled dose at 6 p.m.). We think that expressing pain as a “binary outcome” does not seem logical.

Authors concluded that reduction in postoperative pain and opioid consumption may be translated in to a reduction of postoperative pulmonary morbidity. However in this study, there was no control group and hence it is impossible to determine whether either study technique actually reduces postoperative opioid consumption in comparison to a multimodal analgesic regimen. Breast surgeries are not considered to be risk factor for postoperative pulmonary complications (POPC) and actual incidence of POPC after breast surgeries is also unknown. Hence, benefits of regional analgesia technique in terms of respiratory morbidity in these patients cannot be determined here. The authors have commented that “Concomitant use of regional blocks can not only help to minimize pain, but also improves the pulmonary function and reduce narcotic requirement during the perioperative period;” however, none of the article cited there has made any conclusion regarding pulmonary function.

Despite of a few limitations, we believe that this study will harbor a new era of clinical research in the field of breast cancer surgeries.

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