Authors' reply: Pneumothorax following ultrasound guided supraclavicular brachial plexus block

Sir,

We sincerely thank the authors for their keen interest in our article. It is rightly stated by the authors, that relation of the first rib is of utmost importance during advancement of the needle. We should always aim toward the first rib inferiorly, as it will act as a natural barrier to needle. However, many times it is relatively difficult to maintain this relation, as highlighted by the authors.\(^1\)

Studies are being conducted on giving supraclavicular block in semi sitting position, which may provide a better access of the neck structures. Asking the patient to reach for the ipsilateral knee depresses the clavicle slightly and gives a better access to the anterolateral structures of the neck. This position is more comfortable for the patient and allows for better drainage and lesser prominence of the neck veins. It becomes easier to align the subclavian artery and brachial plexus over the first rib in this position.

The posterior approach, as described by the authors, has shown a resurgence in the last few years, especially, with the use of ultrasonography for the training purposes.\(^1\) However, it has its own set of drawbacks and more studies are required for validating the posterior approach as standard of care.

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Reference

1. van Geffen GJ, Rettig HC, Koornwinder T, Renes S, Gielen MJ. Ultrasound-guided training in the performance of brachial plexus block by the posterior approach: An observational study. Anaesthesia 2007;62:1024-8.
A 14-year-old female presented with complaints of sudden onset of breathlessness and altered sensorium. The past history did not reveal any other comorbid illness. She was diagnosed as a case of accidental OPC poisoning. Trachea was intubated and was treated with appropriate antibiotics. A percutaneous dilatational tracheostomy with 7.5-mm ID was done and was treated with appropriate antibiotics. The patient had one episode of ventilator associated pneumonia (SIMV). Fibreoptic bronchoscopy revealed no pathology. Patient's trachea was reintubated and further ventilation was planned.

She was conscious, hemodynamically stable, normal blood gas trend were normal with no evidence of hypoxia. The patient was ventilated on continuous positive pressure ventilation (CPAP) and then on synchronised intermittent positive pressure ventilation (SIMV). Fibreoptic bronchoscopy revealed no pathology. Patient's aggressive behavior increased gradually in with rigidity in both upper limbs, increased protrusion of tongue and difficulty in opening and closing of mouth and also some features suggestive of catatonia (sudden hyperactivity, rigid posture, mutism). Patient's trachea was intubated and was treated with appropriate antibiotics. A percutaneous dilatational tracheostomy with 7.5-mm ID was done and was treated with appropriate antibiotics. The patient had one episode of ventilator associated pneumonia (SIMV). Fibreoptic bronchoscopy revealed no pathology. Patient's trachea was reintubated and further ventilation was planned.

Her baseline routine investigations were acceptable. A 14-year-old female presented with complaints of sudden onset of breathlessness and altered sensorium. The past history did not reveal any other comorbid illness. She was diagnosed as a case of accidental OPC poisoning. Trachea was intubated and was treated with appropriate antibiotics. A percutaneous dilatational tracheostomy with 7.5-mm ID was done and was treated with appropriate antibiotics. The patient had one episode of ventilator associated pneumonia (SIMV). Fibreoptic bronchoscopy revealed no pathology. Patient's trachea was reintubated and further ventilation was planned.

Initial resuscitation with PAM, atropine and oxygen is considered the mainstays of treatment of OPC poisoning. Atropine psychosis was suspected in this patient due to restless requiring respiratory support was gradually reduced to 2.5 mg HS and thereafter stopped after 10 days. Dose of olanzapine was gradually reduced to 2.5 mg HS and thereafter stopped over 1 week. Dose of olanzapine was gradually reduced to 2.5 mg HS and thereafter stopped over 1 week. Dose of olanzapine was gradually reduced to 2.5 mg HS and thereafter stopped over 1 week. Dose of olanzapine was gradually reduced to 2.5 mg HS and thereafter stopped over 1 week. Dose of olanzapine was gradually reduced to 2.5 mg HS and thereafter stopped over 1 week. Dose of olanzapine was gradually reduced to 2.5 mg HS and thereafter stopped over 1 week. Dose of olanzapine was gradually reduced to 2.5 mg HS and thereafter stopped over 1 week. Dose of olanzapine was gradually reduced to 2.5 mg HS and thereafter stopped over 1 week. Dose of olanzapine was gradually reduced to 2.5 mg HS and thereafter stopped over 1 week.

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