Combination of Regional Anesthetic Blocks for Femoropopliteal Bypass Surgery

To the Editor:

We have read with great interest the article by Basagan-Mogol et al1 entitled “Combination of a Psoas Compartment, Sciatic Nerve, and T12-L1 Paravertebral Blocks for Femoropopliteal Bypass Surgery in a High-Risk Patient.” It is known that general anesthesia increases postoperative complications, and central neuraxial blocks may cause serious sympathetic block and hemodynamic side effects in high-risk patients. For these reasons, peripheral regional anesthesia is generally preferred in high-risk patients.

Basagan-Mogol et al1 used an anesthetic solution consisting of 0.33% bupivacaine with 1/200,000 epinephrine. Kocum et al2 compared the effectiveness of ropivacaine 0.25% and bupivacaine 0.25% for surgical anesthesia and postoperative analgesia during lumbar plexus and sciatic nerve block for high-risk patients with the same volume as the psoas block (30 mL) and the sciatic nerve block (20 mL). Bupivacaine is usually used at the minimum concentration (0.25%) required for surgical anesthesia to reduce the risk as much as possible.3,4 It has been previously reported that 0.25% bupivacaine can provide sufficient surgical anesthesia with combined lumbar plexus and sciatic nerve blocks.4,5 We use this combination of regional techniques and the same concentration (0.25% bupivacaine) and also the same volumes for our high-risk patients undergoing femoropopliteal bypass surgery. In our experience, this technique achieves good patient and surgeon satisfaction during and after the surgical period.

We believe that bupivacaine 0.25% is a sufficient concentration and provides adequate analgesia and safe anesthesia for high-risk patients undergoing femoropopliteal bypass surgery.

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REFERENCES


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Spinal Cord Imaging by Transesophageal Echocardiography

To the Editor:

A 65-year-old female presented for urgent combined aortic valve replacement and coronary artery bypass graft surgery. The patient was diagnosed with severe aortic stenosis on transthoracic echocardiography (aortic valve area of 0.89 cm² and mean pressure gradient of 42 mmHg). During her operation, transesophageal echocardiography (TEE) (Vivid 7; General Electric, Milwaukee, WI) was used for preoperative confirmation of valvular pathology and postoperative assessment of the adequacy of