



LETTERS

Will the Addition of Sciatic Nerve Block to a Femoral Nerve Block Provide Better Pain Control Following Anterior Cruciate Ligament Repair Surgery?

To the Editor: I read with interest the article by Jansen et al in the June 2009 *AANA Journal*.¹ I was dismayed to read the portion dealing with Patients and Methods (pages 213-216) that described the classic LaBat approach” to the performance of sciatic nerve block. The description of the technique and the photograph (Figure 1) supposedly demonstrating the technique did not agree. The photograph does not show the proper technique described in the text.

REFERENCE

1. Jansen TK, Miller BE, Arretche N, Pellegrini JE. Will the addition of sciatic nerve block to a femoral nerve block provide better pain control following anterior cruciate ligament repair surgery? *AANA J*. 2009;77(3):213-218.

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Response: We would like to thank Travis W. Johnson, CRNA, MSN, for his thoughtful and informative response to our article. We agree that the description of the classic Labat approach, detailed in the Patients and Methods section of the manuscript, and the photograph do not appear to agree. In reviewing the photograph, the lines for triangulation are appropriately marked in which the superior line designates

the line between the posterior superior iliac spine to the greater trochanter, and the inferior line indicates the line from the sacral hiatus to the greater trochanter. However, it is hard to determine in the photograph the midpoint of the superior line and if the line for intersection was drawn perpendicular.

In the photograph, an “X” is clearly visible and appeared to be the midpoint that should have been chosen to draw the perpendicular line to the inferior line. However, before placement of the needle, it was discovered that the X mark did not designate the new midpoint, and a new line was redrawn to intersect the superior and inferior lines to mark the place where the needle was to be inserted. The X mark should have been removed before taking the photograph, or another photograph should have been chosen for publication. This was an oversight on our part, and we thank you for bringing this to our attention.

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Comparison of Inhalation of Isopropyl Alcohol vs Promethazine in the Treatment of Postoperative Nausea and Vomiting (PONV) in Patients Identified as High Risk for Developing PONV

To the Editor: In the August 2009 article by Pellegrini et al,¹ the authors discuss administering ondansetron as a prophylactic agent for PONV, 15 to 30 minutes before the conclusion of the surgical procedure. During a literature search for a new pharmacology textbook for Certified Registered Nurse Anesthetists, 3 sources recommend dosing ondansetron *preoperatively*: before any emetogenic medications are administered, to occupy receptors within the chemoreceptor/chemotaxis trigger zone, and presumably to prevent emetogenesis by known triggering agents.²⁻⁴ Two sources describe administering 4 to 8 mg of ondansetron intravenously in adults and 0.05 to 0.15 mg/kg in children over 2 to 5 minutes immediately before the induction of general anesthesia^{2,3} or 30 minutes before the end of surgery.⁴ Also, 16 mg of ondansetron could also be administered orally to adults 1 hour before induction.⁴

The authors describe a future study using inhaled 70% isopropyl alcohol prophylactically immediately before the induction of general anesthesia, in addition to the standard ondansetron prophylaxis 15 to 30 minutes before the conclusion of the surgical procedure. Could the study include comparisons between ondansetron and isopropyl alcohol administered *preoperatively* as described above?

REFERENCES

1. Pellegrini J, DeLoge J, Bennett J, Kelly J. Comparison of inhalation of isopropyl alcohol vs promethazine in the treatment of postoperative nausea and vomiting (PONV) in patients identified as high risk

- for developing PONV. *AANA J.* 2009;77(4):293-299.
2. Sieber FE. *Geriatric Anesthesia*. New York, NY: McGraw-Hill; 2007:233.
 3. Taussig LM, Landau LI. *Pediatric Respiratory Medicine*. 2nd ed. Philadelphia, PA: Mosby. 2008:337-344.
 4. Donnelly AJ, Baughman VL, Gonzales JP, Golembiewski J, Tomsik EA. *Anesthesiology & Critical Care Drug Handbook*. 8th ed. Hudson, OH: Lexi-Comp; 2008:973-976.

Allan Schwartz, CRNA, DDS

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Response: I would like to thank Allan Schwartz, CRNA, DDS, for his letter in which he questioned the validity in administering a prophylactic dose of ondansetron to prevent PONV 15 to 30 minutes before the conclusion of the surgical procedure in our study. Dr Schwartz is correct in citing that ondansetron is recommended by several sources that a prophylactic dose of ondansetron should be

administered in the preoperative period; however, this is not the standard practice used at the institution in which the study was carried out. It is routine at that institution to be administered ondansetron 15 to 30 minutes before the conclusion of the surgical procedure. This practice is based the short half-life of ondansetron (approximately 3-5 hours) and on a body of evidence that indicates that ondansetron may be more efficacious if administered 15 to 30 minutes before the conclusion of the surgical procedure.¹⁻⁴

In response to the second question in which Dr Schwartz asks if we could do a comparison between ondansetron and IPA administered prophylactically, I regret to say that we have already concluded that study following the same methodology described in the previous studies. Nevertheless, this is an

interesting question and should be considered for future studies.

REFERENCES

1. Sun R, Klein KW, White PF. The effect of timing of ondansetron administration in outpatients undergoing otolaryngologic surgery. *Anesth Analg.* 1997;84(3):331-336.
2. Tang J, Wang B, White PF, Watcha MF, Qi J, Wender RH. The effect of timing of ondansetron administration on its efficacy, cost-effectiveness, and cost-benefit as a prophylactic antiemetic in the ambulatory setting. *Anesth Analg.* 1998;86(2):274-282.
3. Apfel CC, Korttila K, Abdalla M, et al. A factorial trial of six interventions for the prevention of postoperative nausea and vomiting. *N Engl J Med.* 2004;350(24):2441-2451.
4. McCracken G, Houston P, Guylaine L. Guideline for the management of postoperative nausea and vomiting. *J Obstet Gynaecol Can.* 2008;30(7):600-607, 608-616.

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Correction

In the State of the Science General and Oral Poster Sessions, published in the October 2009 *AANA Journal*, the title for abstract A55 on page 397 was incorrect. The correct title is "Implementation of Stress Reduction Techniques in Nurse Anesthesia Students." The abstract appears correctly on the AANA website.