In summary, a review of the clinically relevant literature reveals two conclusions: 1) a single-injection axillary block will not reliably block all the nerves, and 2) paresthesia techniques may or may not result in an increased incidence of postanesthetic neuropathy. As Selander himself has stated, "Any technique which results in good block without injury to the patient is a good technique." We need well-designed clinical studies to determine the true incidence of paresthesias following various techniques. We also need well-designed clinical studies which will quantify the degree of neural blockade following axillary block by various approaches.

JAMES J. GIBBONS, M.D.
Fellow in Regional Anesthesia and Pain Management

ROBERT L. LENNON, D.O.
Assistant Professor of Anesthesiology

STEVEN H. ROSE, M.D.
Instructor in Anesthesiology

DENISE J. WEDEL, M.D.
Assistant Professor of Anesthesiology

BETH E. GIBSON, M.D.
Instructor in Anesthesiology

Department of Anesthesiology
Mayo Clinic
Rochester, Minnesota 55905

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Use of a Nerve Stimulator for Peripheral Nerve Blocks. I.

To the Editor:—In response to the article by Goldberg *et al.*,[1] our experience with electrolocation has been quite different.

At our small community hospital, five university-trained anesthesiologists began using electrolocation after dissatisfaction with paresthesia, sheath, and transarterial axillary block methods. Training in electrolocation consisted of viewing training tapes and discussion with an anesthesiologist experienced in electrolocation.

Our retrospective review showed 142 electrolocation blocks performed over 23 months, with results as follows:

Site	Total Blocks	# Failures	% Success
Axillary brachial plexus	122	7 (4 awakened from general anesthesia with good relief)	95.1%
Interscalene brachial plexus	11	0	100%
Femoral, sciatic, intercostal, others	9	0	100%

All blocks were performed with the same nerve stimulator used by the authors, and with insulated needles. Success was defined as adequate analgesia from the nerve block with judicious amounts of sedation (verbal contact maintained with patient) and *occasional* use of *small* amounts of local anesthetic infiltrated for "hot spots."

THOMAS E. FORTE, D.O.
KUN I. LEE, M.D.
1550 Oak Knoll Drive
Cincinnati, Ohio 45224

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