

Anesthesiology
72:580, 1990

In Reply:—Dr. Meakin refers to two studies^{1,2} in which subjects were permitted either tea and toast as part of the study protocol, or cereals and milk on the day of surgery prior to entry into the study. We believe that the administration of solids on the day of surgery may be a contributing factor to the difference between our study and those studies quoted. In addition, those studies did not use a mechanism to differentiate between ingested liquid and endogenous gastric secretion. For these reasons, our investigation is not directly comparable.

In our study,³ we have used a marker dye to differentiate between ingested fluid and endogenous gastric secretion. No PSP was found in gastric aspirate when the ingestion-surgery interval exceeded 135 min—and dye retrieval was less than 5% in all subjects who had gastric aspirates obtained greater than 1 h after the ingestion of dye. In this group of patients, gastric fluid aspirate more than 135 min following ingestion reflected endogenous gastric secretion. In addition, the administration of clear liquid will not significantly affect gastric fluid pH or volume when measured 90–250 min after ingestion. Because of these findings, we have recommended reassessment of present guidelines that may severely restrict the administration of preoperative fluids.

Since publication of our investigation, two additional groups of investigators have completed studies^{1,2} that recommend reducing the minimum fasting interval for unlimited clear liquids to 2 h. Considering the available evidence, when will reassessment be prudent?

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REFERENCES

1. Triebwasser A, Schreiner MS, Parness J, Keon TP: Effect of preoperative clear fluids gastric volume in children (abstract). *ANESTHESIOLOGY* 71:A1177, 1989
2. Zunder IH, Splinter WM, Schaefer JD: Preoperative clear fluids do not affect gastric pH and volume in children (abstract). *ANESTHESIOLOGY* 71:A1063, 1989
3. Sandhar BK, Goresky GV, Maltby JR, Shaffer EA: Effect of oral liquids and ranitidine on gastric fluid volume and pH in children undergoing outpatient surgery. *ANESTHESIOLOGY* 71:327–330, 1989

(Accepted for publication December 21, 1989.)

Anesthesiology
72:580–581, 1990

Suprascapular Nerve Block: A Safer Technique

To the Editor:—Suprascapular nerve blocks were one of the first nerve blocks popularized by Bonica¹ and were used for the management of a variety of chronic pain syndromes including rotator cuff syndrome, "frozen shoulder," myofascial pain syndrome, and chronic capsulitis of the shoulder.

This block is usually performed by injecting 10 ml of 0.25% bupivacaine (with or without methylprednisolone) at a point one-finger breadth superior to the midpoint of the spine of the scapula.² A paresthesia is usually sought and obtained approximately 3–4 cm from the surface of the skin. The suprascapular nerve emerges through the suprascapular fossa at that point. In a limited number of patients (particularly asthenic patients) the needle could make contact with one of the ribs of the posterior chest wall. It is also possible that the needle could pass between the ribs on the posterior chest wall and penetrate the lung, producing a pneumothorax.

The purpose of this letter is to draw attention to a technique that may reduce the risks of this potential complication. In this technique, after the needle is introduced for half a centimeter at the appropriate point into the skin, the upper extremity (on the same side of the block) is flexed at the elbow and rotated medially so that the hand is removed from the anatomical position and placed on the opposite shoulder. This movement causes elevation of the scapula away from the posterior chest wall (figs. 1 and 2) thus increasing the potential distance that a needle would have to travel from the skin to the chest wall while paresthesiae are being sought. This maneuver may prevent an inadvertent

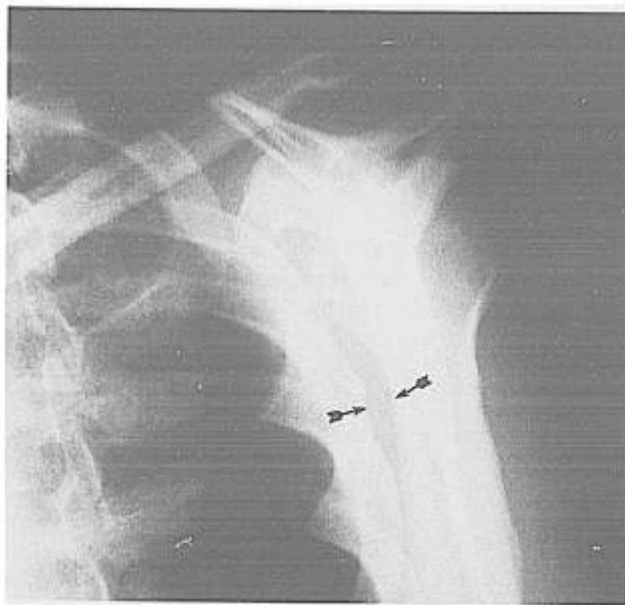


FIG. 1. Chest radiograph: oblique view (with arm in the anatomical position) showing distance between chest wall and scapula.