Correspondence

Spinal anaesthesia for elective surgery

Editor—As someone who regularly performs spinal anaesthesia in orthopaedic and obstetric patients, I read with particular interest the recent article by Luck and colleagues.\(^1\) I was disappointed that in this era of litigiousness, the authors still routinely insert a spinal needle at the second lumbar interspace. We know from previous studies that even experienced anaesthetists are actually one space above the space they think they are at.\(^2\) Thus, routinely aiming to place a spinal needle at L2–L3 risks placing the needle at L1–L2 or above thus risking injury to the conus medullaris. I think this article sends out the message that performing spinal anaesthesia at L2–L3 is routine. I now routinely recommend to trainees that spinal anaesthesia should not be performed above L3–L4, unless there are exceptional circumstances. In fact, I recommend that they choose L4–L5 as the default space for performing a spinal block as technically they are no more difficult to perform and block height is not affected by giving the spinal solution at L4–L5. It will be interesting to see the results of the National Audit on Regional Anaesthesia in January of 2009 which will give us an indication of what the national practice is regarding spaces at which spinal needles are performed and their relative risks.

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Editor—With respect, our paper does not state ‘that performing spinal anaesthesia at L2–L3 is routine’.\(^1\) It says that in a tightly controlled study of hyperbaric solutions of three different drugs, the solution was injected at either ‘the second or third lumbar interspace’, and also says that there were ‘no major sequelae’. This study was the latest in a series which goes back many years and has used exactly the same protocol (including close patient follow-up) in several hundred patients, all without sequelae. Raising issues of ‘litigiousness’ suggests negligent practice and we take some exception to that. It is our routine clinical practice to use the third lumbar interspace, with the second being used as the default, and this is what happened in the study, with the iliac crests (or the vertebra prominens in cases of difficulty) being used as the key landmark in a fully flexed (a key point we believe) patient.

We are very aware of the issue of vertebral level, two of us having written an editorial for this Journal reviewing the many factors involved.\(^3\) Briefly, we consider that it is impossible to guarantee that the needle is inserted below the spinal cord because of its variable termination\(^4\) and the difficulty of identification of spinal level.\(^2\) In addition, even when the needle is inserted below the cord, it is still directed at the cauda equina. Thus, the needle must be inserted gently and carefully if injury is to be avoided. With the exercise of appropriate care, spinal anaesthesia can be performed at mid-thoracic level without damaging the spinal cord.\(^5\)

We have some concern over the advocacy of the fourth lumbar interspace, and do not accept that the level of injection does not affect the eventual level of block.\(^6\) Hyperbaric solutions, particularly, may become ‘trapped’ on the caudal side of the lumbar curve if they are injected at too low a level, the result being a very restricted block which is probably inadequate for surgery, and even plain solutions may be more restricted in spread than is usual. Further, it is our experience that the frequency of failed lumbar puncture is much greater if too low a level is used for needle insertion. However, if Dr Sumaiya finds that this level is successful in routine practice, perhaps we have to conclude that ‘his’ L4–L5 is ‘our’ L3–L4!

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General anaesthesia for intralesional bleomycin therapy of vascular malformations: initial 3 yr experience

Editor—Intralesional bleomycin therapy is a relatively new and effective treatment for vascular malformations.\(^1\) 2