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# Letters to the Editor

To the Editor:

Drs DeSalvo and Muntner are to be congratulated for confirming that in some settings patients' perception of their health status can be more predictive of outcomes than the perceptions of treating physicians (''Discordance Between Physician and Patient Self-Rated Health and All-Cause Mortality,'' *The Ochsner Journal*, Volume 11, Number 3). As the authors state, their findings should be confirmed and refined because the use of a validated predictive health status questionnaire could prove of great value not only in improving care by focusing effort on high-risk populations but also in terms of lowering costs. In these future studies, it would be interesting to also explore physician and insurance plan attributes that are associated with better or worse accuracy of health assessment. Specifically, it would be worth knowing if the frequency of patient interaction with a physician improves concordance of health assessment—in the authors' study the patient was seen only once by the physician. Would more frequent interactions help? Do payment plans such as HMO or PPO influence concordance? Determining the answers to these questions could permit improvements in the assessment of healthcare status even in settings in which a validated questionnaire is not available.

Richard N. Re, MD
Ochsner Clinic Foundation
rre@ochsner.org

To the Editor:

The John Adriani story (''Anesthesiology – The John Adriani Story,'' *The Ochsner Journal*, Volume 11, Number 1) touched a fiber of my youth. As a pathology resident in the Department of Pathology in the LSU program, I had the honor of meeting and working with Dr Adriani. I knew, as a young officer at the Charity Hospital, that he was a very important person in the world of anesthesia, but it was not until I read your wonderful article that I appreciated the scope of his work and real value.

Unfortunately, the power of the ''drug'' companies has not diminished with the years but is as strong as ever.

Thank you for giving us the opportunity to realize the true value of a pioneer in the world of medicine.

Soffy Botero, MD
New Orleans, LA

To the Editor:

I read with interest the recently published study by Thomas et al (''Comparison of Ultrasound and Nerve Stimulation Techniques for Interscalene Brachial Plexus Block for Shoulder Surgery in a Residency Training Environment: A Randomized, Controlled, Observer-Blinded Trial,'' *The Ochsner Journal*, Volume 11, Number 3) comparing the use of ultrasound guidance versus nerve stimulation for performing interscalene nerve blocks in the setting of a residency training environment. This study gives a new perspective on the practice of nerve block techniques done while in residency training. The question of whether to use ultrasound or nerve stimulation for nerve blocks occurs daily in anesthesia residency programs across the country. I believe that many residents elect to do ultrasound-guided nerve blocks more out of perceived convenience and accuracy rather than knowing what the literature supports.

Ultrasound-guided nerve blocks have been reported in the anesthesia literature since 1978, with significantly increased interest beginning the mid-1990s. One reason for the increasing popularity in ultrasound-guided nerve blocks may be attributed to improved ultrasound equipment. In 2007, Casati et al found that ultrasonography and neurostimulation have similar success rates, patient satisfaction, and incidence of complications after multiple injection axillary brachial plexus block with as little as 20 mL of local anesthetic solution.[1]

After 2007, several studies stated (in agreement with the authors) favorable outcomes using the ultrasound for nerve blocks. Sauter et al (2008) concluded that although both methods were similar, ultrasound was more feasible.[2] In 2009, a review and meta-analysis of randomized controlled trials by Abrahams et al[3] compared the use of ultrasound and neurostimulation for peripheral nerve blocks. They concluded that ultrasound guidance for peripheral nerve block produced a higher rate of block success, shorter procedure time, faster onset time, and longer block duration. They also concluded that ultrasound guidance appeared to reduce the risk of inadvertent vascular puncture during block performance.

Another review article by Salinas et al in 2010 found that ultrasound guidance provides improvements in the onset and success of sensory block, a decrease in local anesthetic requirements, and decreased time to perform the lower extremity peripheral nerve blocks.[4]

Although multiple studies have discussed this concept, the study by Thomas et al is unique because of its setting in the residency training program. I believe that this particular study will influence the practice of nerve blocks in residency training programs nationwide.

Most of the previously published studies and the current study published in *The Ochsner Journal* were carried out on small sample patient populations. My question to the authors is whether they plan to enroll more patients so that they can publish a large randomized clinical trial and, hopefully, provide a definitive answer to the discussed topic?

Again, I want to congratulate the authors for all of their hard work to produce such a study article. We need more of these kinds of studies to improve our daily practice. I hope that they will continue their work and publish a large randomized clinical trial in the near future.

Alaa A. Abd-Elsayed, MD, MPH
Department of Anesthesiology, University of Cincinnati
Cincinnati, OH
email: alaaawny@hotmail.com

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To the Editor:

The recent article by Thomas et al (''Comparison of Ultrasound and Nerve Stimulation Techniques for Interscalene Brachial Plexus Block for Shoulder Surgery in a Residency Training Environment: A Randomized, Controlled, Observer-Blinded Trial'') considers whether ultrasound (US)-guided regional anesthesia should be the technique of choice when compared to nerve stimulation (NS) in a training institution. While administering regional anesthesia under US guidance has now become fairly commonplace in the academic setting, not long ago the technique was still gaining acceptance. Many of us recent anesthesiology graduates likely referred to the popular regional anesthesia textbook by Hadzic and Vloka and other resources offered by the New York School of Regional Anesthesia to learn our techniques.[1] Not until the more recent 2006 textbook by Hadzic did US-guided techniques appear in their resources.[2] Thus, our anesthesia colleagues who were already adept at NS-guided blocks have had to relearn these same techniques under US guidance. US has made teaching nerve blocks easier as instructors can demonstrate anatomy in real time and with the added benefit of improved success by novices. Developing and teaching new technologies while balancing efficiency and best possible patient outcomes is a challenge of practicing in an academic center. However, this study provides further evidence that even in a training environment US-guided blocks can be done quickly and with consistent success that should be embraced by surgeons, anesthesiologists, and patients alike.

Nathan J. Harrison, MD
Department of Anesthesiology, Ochsner Clinic–Covington
nharrison@ochsner.org

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To the Editor:

The work by Stanley et al addressing quality of life in hypertensive patients following Hurricane Katrina (''Quality of Life in Hypertensive Clinic Patients Following Hurricane Katrina,'' *The Ochsner Journal*, Volume 11, Number 3) adds to a growing body of literature addressing postdisaster healthcare problems. The authors describe their findings that included high rates of stress and difficulty coping among hypertensive patients. The survey found that those who had their homes damaged or those who had found themselves at increased distance from family and friends had significantly lower scores on quality-of-life indicators.

Other studies have shown healthcare problems arising in diabetic populations, cardiac patients, end-stage renal disease patients, and geriatric populations following disasters.[1-4] A number of studies have shown persistent mental health care problems in postdisaster victims.[5,6] The authors also point out findings indicating that emotional stress contributes to cardiovascular events, including high rates of stroke and myocardial infarction.

The astute clinician will reach out to patients in postdisaster environments to question them regarding factors known to be associated with increased stress following such disasters. By proactively addressing issues relating to mental health and emotional adjustment, the physician may improve the patient's emotional well-being as well as lower the patient's risk of cardiovascular events and death.

As this study shows, we should recognize that the human cost of a disaster does not end when the wind stops blowing and the water stops rising.

Richard Deichmann, MD, FACP
The University of Queensland, Ochsner Clinical School
rdeichmann@ochsner.org

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