Rashid M. Khan MD*
 Mohammed Maroof MD†
 Seema Hakim MD*
 Divya Jain MBBS*
 Moin Ashraf DA*
 Aligarh, India*
 Charlotte, North Carolina†

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More on regional anesthesia induction rooms

To the Editor:

I would like to comment on a recent editorial on the interest of an induction room.¹ Basically, the creation of an induction room involves four issues: quality of anesthesia care; functioning costs; timing of patient management; and benefits for teaching.

Cost issues involve the salary of a medical assistant and expenses related to running an additional “operating” room. However, when the patient is successfully blocked, his/her stay in the operating room is shortened as induction is eliminated, and there are no additional anesthetic expenses. The anesthesiologist remains available for the next block procedure and after surgery, the patient can bypass the recovery room, saving money, occupational time and a bed. Thus, a functioning induction room represents a transfer of activity rather than new activity.

In institutions doing mostly local anesthetics (no required “soak” time for block installation) or when regional techniques are occasional, an induction room is of lesser interest. Conversely, when the load of conduction block patients is heavy, an induction room allows optimizing the occupation time of up to three operating rooms. Performing a plexus block requires approximately 30 min (equipment/medication set-up, procedure and clean up): up to 16 patients per-eight hour day can be treated. When adding the time for block installation (30 min, no staff assistance required), one hour of operating room time can be spared for each successfully blocked patient.

Lastly, an induction room is more suited for teaching regional anesthesia than can be a busy operating room with awaiting surgeons.

Bernard Dalens MD
 Sainte-Foy, Québec

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- 1 Drolet P, Girard M. Regional anesthesia, block room and efficiency: putting things in perspective (Editorial). *Can J Anesth* 2004; 51: 1–5.

Peripheral oxygen saturation falls in the lateral lumbar puncture position

To the Editor:

In the lateral lumbar puncture (LLP) position, patients are asked to bend forward as much as possible. This can restrict chest wall movement and provoke hypoxemia. However, little has been reported on the changes in partial pressure of arterial oxygen or peripheral oxygen saturation (SpO₂) in the LLP position.^{1,2} We observed the changes in SpO₂ using a pulse oximeter (N-395, Nellcor Puritan Bennett Inc., Pleasanton, CA, USA) during the time 60 patients (ASA physical status I–IV, 19–78 yr, 21 male and 39 female) assumed the LLP position. We also investigated whether the administration of oxygen (3 L·min⁻¹) prevents SpO₂ decrease.

Before the day of surgery, we measured the changes in SpO₂ when the patients were in the sitting, supine and LLP positions in the ward. Patients were divided into two groups: a low group (lowest SpO₂ less than 97%, *n* = 34) and a high group (lowest SpO₂ equal to or more than 97%, *n* = 26). In the operating room, the low group patients received oxygen (3 L·min⁻¹) by nasal cannulae during spinal and/or epidural puncture.