*et al.*¹ Catheter placement lasted five minutes. In the postoperative period, a continuous infusion of 5 mL·hr⁻¹ of ropivacaine 0.2% with a 5-mL patient-controlled bolus available every 30 min was used. During the first 48 hr of follow-up, only one bolus was necessary for excellent pain control.

In emergency conditions, such as those illustrated in these two cases, the IC approach, that does not require upper limb abduction (often limited by pain), appears to be an interesting alternative to the axillary block. When compared to the interscalene approach, the IC approach provides a greater extent of block (ulnar nerve) with less side-effects.² Pneumothorax is the main risk which decreases significantly with the use of a lateral technique.^{1,3}

The procedure is rapid 3 (2–6) min and latency is short 19.5 (15–30) min [median (range)].⁴ In a recent study, the success rate was improved using a double-stimulation technique with 30 mL of local anesthetic as compared to a single 40-mL injection.⁵ The possibility to insert a catheter is especially interesting in emergency procedures where often the time and the duration of surgery are difficult to anticipate, allowing good analgesia during the perioperative period.

In summary, the infraclavicular block offers a good alternative to the classic axillary approach, especially in emergency conditions when movement of the patient's arm is reduced.

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What do we do with a disconnected epidural catheter? - A response

To the Editor:

We read with interest the letter of Parry¹ concerning disconnection between the epidural catheter and its luer-lock connector. We would like to comment on a simple technique to reduce if not eliminate this problem.

In our practice, we use an Arrow FlexTip Plus® catheter (Arrow International, Inc., Reading, PA, USA) which is attached to Arrow's SnapLock™ adapter (Arrow International, Inc., Reading, PA, USA) by a single "snap." Other catheters with a screw cap may not be tightened enough on the catheter and have the potential to disconnect.

The catheter is then taped with a double loop to the adapter as described by Rivard *et al.*² Once the adapter is connected to the tubing of the epidural pump, the epidural catheter along with the adapter and the pump tubing are looped and taped to the patient's shoulder. We check if the epidural catheter is secured properly every hour for labour and delivery, and twice a day post-Cesarean section.

We apply this technique for labour epidural, as well as post-Cesarean section epidural-patient controlled analgesia infusion for up to three to four days. We have used this technique for more than 500 patients a year for five years, without any incidence of epidural disconnection.

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