of anesthesia in hypertensive patients when considering the poor value of the bispectral index, of end-tidal concentration of sevoflurane or its duration of administration in predicting the depth of anesthesia and the hemodynamic reaction to nociceptive stimuli.

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Transthoracic echocardiography pre-, intra-, and postoperatively

To the Editor:

We fully agree with Hadiç and co-authors concerning the use of transthoracic echocardiography (TTE) in the perioperative period.¹ In addition to its use pre- and postoperatively, we use TTE as an intraoperative noninvasive hemodynamic monitor in patients with severe cardiac disease undergoing surgical procedures in

regional anesthesia. Thus, our indications for perioperative use of TTE include: 1) preoperative TTE to evaluate unclear cardiac status, e.g. clinical suspicions of aortic stenosis, in patients needing urgent surgery but no immediately available cardiologist-echocardiographer, 2) intraoperative TTE to monitor patients with severe cardiac disease undergoing surgery in regional anesthesia, and 3) postoperative TTE in patients with severe hemodynamic instability occurring after extubation. The use of TTE by anesthesiologists prevents unnecessary delays of surgery, allows extended noninvasive hemodynamic monitoring during regional anesthesia, and facilitates postoperative patient care. To obtain appropriate information from TTE, anesthesiologists-echocardiographers performing TTE need formal training in the transthoracic echocardiographic approach.

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- 1 Hadiç A, Vloka JD, Koorn R, Thys DM. Transthoracic echocardiography in perioperative medicine (Letter). *Can J Anesth* 1999; 46: 616.

Axillary blockade by the targeted method. Added benefit?

To the Editor:

We wish to comment on the article by Korscielniak-Nielsen *et al.*¹ regarding upper limb brachial plexus blockade by the targeted approach. First, the authors claim that this approach reduces total anesthetic time compared with the single injection approach because block supplementation for the single-injection recipients was time-consuming. However, the success rates for complete blockade in the single-injection group was only 54%. Even when the author excludes those supplementary blocks unnecessary for surgery, success increased to only 65%. This is a high failure rate. Most studies produce successful blockade in 85–100% of subjects^{2–6} and the single-injection technique is faster. Second, 22% of the targeted group experienced tourniquet pain, compared with 4% in the single-injection group. As brachial plexus blockade is the regional technique of choice for prolonged surgery, tourniquet pain to this degree may become a limiting factor when using the targeted approach. Third, the author states that the