in the treatment group had lower pain scores, reduced opioid consumption and no long-term complications.

At the Vancouver Hospital we have used intercostal cryoneurolysis in over 1500 thoracotomy patients. Since 1988 we have reduced the duration of each cryosession to 30 sec and our thoracic surgeons report that the incidence of numbness or dysaesthesia lasting more than two months is virtually zero. Cryoanalgesia remains an important component in the management of thoracotomy pain at our hospital, as at other centres.⁶

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Posterior lumbar plexus block

To the Editor:

I wish to congratulate Farny *et al.* on their work on the posterior lumbar plexus block.^{1,2} They have described in detail the relevant anatomy of the lumbar plexus.¹ They have quite convincingly demonstrated that there is no "psoas compartment" into which local anaesthetic can be deposited other than the psoas muscle itself. This observation has important implications. For example, there is a great deal of evidence to suggest that local anaesthetic does not travel proximally to the lumbar plexus by a common fascial compartment following a femoral 3-in-1 nerve block³ as suggested by Winnie.⁴ This is because such a compartment does not exist as demonstrated by Farny *et al.*¹ and Ritter.⁵

In clinical study by Farny *et al.*² there are some methodologic flaws and their conclusions may be unfounded. They stated that the purpose of the study was "to define the clinical potential of posterior lumbar plexus blockade

when combined with a sciatic nerve block" and "that the combination of these two blocks is necessary to provide anaesthesia to the entire lower extremity." Successful blocks were defined as the ability to perform surgical procedures on the lower extremity (principally ankle surgery or knee arthroscopy) without conversion to general anaesthesia. This would have been an acceptable endpoint if the surgical procedures involved had required anaesthesia in all of the nerves to the lower extremity. However, 33 of 45 patients underwent knee arthroscopy with or without meniscectomy and these surgical procedures do not require sensory anaesthesia of both the sciatic nerve and the lumbar plexus. They are commonly performed with only intra-articular local anaesthetic and intravenous sedation and analgesia.⁶ Twenty-two of 45 patients had surgical procedures below the knee and sciatic nerve block with or without a saphenous nerve block may be all that is necessary.

The authors advocate this technique for outpatient surgery. They state that surgery started 35 ± 24 min after the end of the second block. The time to completion of the blocks averaged 8 ± 5.9 min (range 3-40 min). The patients left the hospital 337 ± 49 min after the blocks. In our institution arthroscopic meniscectomy takes 20 to 30 min to perform and patients go home within one to two hours of the surgery which is performed with intra-articular local anaesthetic.

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