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Lower extremity temperature disparity after retroperitoneal dissection

To the Editor:

Combined chemotherapy and radical surgery are employed to treat patients with testicular carcinoma. Scardino and Skinner have demonstrated bleomycin and cisplatin therapy followed by thoracoabdominal dissection to be curative.¹ Surgery involves resection of retroperitoneal tissue and lymphatics from the pelvis to the diaphragm.^{2,3} Postoperatively, 30 - 40 % of these patients present with temperature disparity between the lower extremities.

A temperature difference of this type raises concern about a cold extremity and possible vascular insufficiency or embolic complication - and can result in extensive additional workup. Furthermore, heparinization may be considered and increase the risk of postoperative bleeding. On examining these patients, we have found that the warmer leg is on the same side as the surgery, and Doppler studies consistently fail to demonstrate vascular abnormalities. Surgical dissection involves removal of retroperitoneal tissue which may include sympathetic ganglia and nerve fibres. This results in vasodilatation and production of warmth in the ipsilateral lower extremity. The temperature difference is typically 2 to 3°C and partially resolves over several weeks.

Lower extremity temperature disparity can result from (i) less warmth in one extremity secondary to decreased blood supply or from (ii) relatively more warmth in one extremity secondary to comparatively increased blood flow (as discussed here). Clinically, discriminating between these two etiologies is difficult because expected postoperative temperature variability makes it impossible to label one limb's temperature as *normal*.

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Interscalene brachial plexus block and pulmonary function

To the Editor:

We compared the effects of posterior and lateral approaches to Interscalene Brachial Plexus Block (IBPB) on respiratory function. Fifty consecutive ASA I-II patients, scheduled for elective upper extremity surgery were studied. Arterial blood pressure, ECG and peripheral oxygen saturation were monitored during the surgical procedure. The subjects were randomly allocated in two groups of 25. Interscalene brachial plexus block was performed by the lateral approach of Winnie¹ in group I and by the posterior approach of Pippa *et al.*² in group 2. In both groups 40 ml of anesthetic solution (20 ml prilocaine 1% and 20 ml bupivacaine 0.5% were administered. Respiratory function measurements were performed in the operation room using Autospiro AS 500 apparatus (Minato, Japan). Forced vital capacity (FVC), Forced Expiratory Volume at first second (FEV₁), and

TABLE Decrease (%) in respiratory function after IBPB.

	2 min		5 min		10 min		15 min		30 min	
Group	I	II	I	II	I	II	I	II	I	II
FVC	13.4*	15.5*	17.0*	21.0*	20.3*	22.2*	25.3*	30.1*	25.6*	32.2*
FEV ₁	11.8*	11.1*	15.0*	19.1*	19.6*	24.4*	24.1*	29.1*	25.2*	31.1*
VC	18.7*	18.8*	24.0*	31.0*	27.1*	33.8*	28.2*	38.2*	29.5*	37.3*

* $P < 0.05$ compared with baseline measurements.