

TABLE Results from survey performed on 86 patients. Numbers listed indicate percentages

Questions:	Options	Overall (%)
Is the anesthesiologist a physician?	Yes	80.2
	No	19.8
What is the primary role of the anesthesiologist?	Assistant to the surgeon	38.4
	Physician	36.0
	Technical expert	22.1
	Non-physician health care professional	3.5
Who is the main person in charge of resuscitating a patient in the operation room?	Cardiologist	31.4
	Surgeon	30.2
	Anesthesiologist	27.9
	Nurse	10.5
Who is the main person deciding for a blood transfusion in the operation room?	Hematologist	44.2
	Surgeon	43.0
	Anesthesiologist	10.5
	Nurse	2.3
Who is the main person maintaining vital signs in the operation room?	Anesthesiologist	45.3
	Cardiologist	25.6
	Nurse	23.3
	Surgeon	5.8
Do you have a preference for your attending anesthesiologist?	Yes	3.5
	No	96.5
What is the initial technique of putting a patient to sleep?	<i>iv</i> injection	53.5
	Gas	18.6
	Pills	2.3
	Do not know	25.6
What is the main technique to keep the patient asleep?	<i>iv</i> injection	39.5
	Gas	17.4
	Do not know	43.0
	Awakening during the surgery	26.7
Concerns associated with general anesthetics:	Prolonged awakening time	24.4
	Negative reaction to drugs	23.3
	Overdose	19.8
	Anesthesiologist	33.7
Association with inability to awaken after surgery:	Drugs	14.0
	Surgeon	9.3
	Type of surgery	7.0
	Patient	7.0

drugs (41% *vs* 15%,  $P = 0.01$ ) compared to patients  $\geq$  age 55. Previous experience with anesthetics did not affect their knowledge about anesthesia.

In summary, the majority of patients acknowledged anesthesiologists as physicians; yet, most patients thought anesthesiologists were assistants to surgeons and did not identify them to be the principle person responsible for resuscitation or blood transfusions in the operating room. Improved communication with, and education of, patients may help correct misconceptions about anesthesiologists in the future.

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#### References

- 1 *Klafta JM, Roizen MF*. Current understanding of patients' attitudes toward and preparation for anesthe-

sia: a review. *Anesth Analg* 1996; 83: 1314–21.

- 2 *Garcia-Sanchez MJ, Prieto-Cuelar M, Galdo-Abadin JR, Palacio-Rodriguez MA*. Can we change the patient's image of the anesthesiologist? (Spanish). *Rev Esp Anesthesiol Reanim* 1996; 43: 204–7.
- 3 *Adachi Y, Watanabe K, Satoh T*. The evaluation of pre-operative anesthetic visit in our hospital (Japanese). *Masui* 1999; 48: 1037–42.
- 4 *Huang Y, Yang K, Ren H, Luo A*. A survey of elective surgical patients' attitudes toward anesthesia in PUMC hospital. *Chin Med Sci J* 2002; 17: 77–80.

#### *Ankle block success rate: a prospective analysis of 1,000 patients*

To the Editor:

There have been few published studies investigating ankle block success.<sup>1</sup> We therefore conducted a prospec-

tive audit of 1,000 ankle blocks for mid or forefoot surgery. Aims were to determine block success rate, risk factors for block failure and length of action of differing combinations of local anesthetic (LA). The choice of LA was either a 50/50 mixture of lidocaine 1.5% plain and ropivacaine 7.5 mg·mL<sup>-1</sup>, ropivacaine 7.5 mg·mL<sup>-1</sup> alone, or ropivacaine 7.5 mg·mL<sup>-1</sup> and clonidine 1 µg·kg<sup>-1</sup>. A standardized ankle block technique was used using a 40 mL total maximum volume with optional sedation for block and surgery. Using a 25 gauge 35-mm needle, the tibial nerve was blocked with up to 10 mL LA at the medial malleolar level, posterior to the posterior tibial artery pulsation. The saphenous and superficial peroneal nerves were blocked by infiltration of 10 to 15 mL LA along a line joining both malleoli and the sural nerve with up to 10 mL LA infiltrated 1.5 cm distal to the tip of the fibula. The deep peroneal nerve were blocked at the malleolar level, with up to 5 mL LA between bone and skin (both sides of the dorsalis pedis pulsation). A 15-cm wide low-pressure ankle tourniquet (Zimmer, Warsaw, Indiana) was applied at the supramalleolar level and inflated to a pressure of 250 mmHg for surgery. A successful block was defined as one that did not require surgical supplementation, *iv* sedation or general anesthesia (GA) for surgery.

Overall block success rate was 94.7%, with a 4.4% improvement over the last 700 cases. The failure rate when surgery commenced before 20 min from block insertion was significantly ( $P < 0.001$ ) greater than for longer waiting periods; there was a sharp drop in failure as waiting periods increased (Figure). Nine

patients required GA (3 tourniquet pain, 2 block failures, 3 anxiety, 1 confused). Ropivacaine with clonidine had a significantly longer mean duration of action at 15.9 hr compared to other LA agents ( $P < 0.001$ ).

In conclusion, compared to popliteal block, our ankle block audit demonstrated a high success rate, with a longer period of analgesia with the addition of clonidine.<sup>2-4</sup> Few patients (0.2%) required GA for block failure. LA supplementation and sedation is required more often with surgery commencing within 20 min. Time constraints may be a major impediment for clinicians performing ankle blocks, as recognized in work published recently.<sup>5</sup>

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## References

- 1 Myerson MS, Ruland CM, Allon SM. Regional anesthesia for foot and ankle surgery. *Foot Ankle* 1992; 13: 282-8.
- 2 Provenzano DA, Viscusi ER, Adams SB Jr, Kerner MB, Torjman MC, Abidi NA. Safety and efficacy of the popliteal fossa nerve block when utilized for foot and ankle surgery. *Foot Ankle Int* 2002; 23: 394-9.
- 3 Singelyn FJ, Gouverneur JM, Gribomont BF. Popliteal sciatic nerve block aided by a nerve stimulator: a reliable technique for foot and ankle surgery. *Reg Anesth* 1991; 16: 278-81.
- 4 McLeod DH, Wong DH, Vaghadia H, Claridge RJ, Merrick PM. Lateral popliteal sciatic nerve block compared with ankle block for analgesia following foot surgery. *Can J Anaesth* 1995; 42: 765-9.
- 5 Rudkin GE, Micallef TA. Impediments to the use of ankle block in Australia. *Anaesth Intensive Care* 2004; 32: 368-71.

## *Intracerebral hematoma after combined spinal-epidural anesthesia: complication or coincidence?*

To the Editor:

Intracerebral hemorrhage (ICH) is most frequently a spontaneous event. When following regional anesthesia, the link seems *a priori* evident and relevant.

A 50-yr-old alcoholic woman became comatose two days after hemorrhoidectomy. For the procedure, a combined spinal-epidural (CSE) had been performed at the L4-L5 level using a 27-gauge pencil-point needle

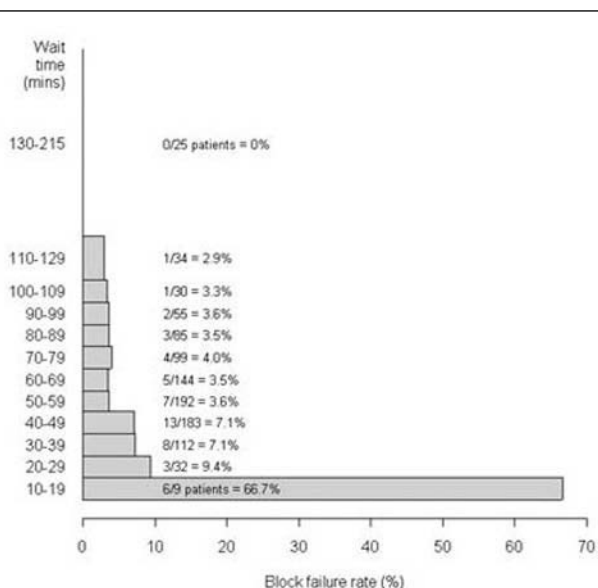


FIGURE Relationship between waiting time and block failure.