When I paged through this issue of our journal, it gave me great hope for the future of Anaesthesia in our country. We have a large number of South African submissions, and all of the registrar submissions for the registrar communication prize at our 2010 SASA congress. I am sure you will all agree that the standard of these entries is high, and thus bodes well for our future specialists.

We have received many letters, and I am including one as part of my editorial, as it highlights an important aspect of regional anaesthesia.

Christina Lundgren
Editor-in-chief

When will the sonar ping reach our shores?

After attending the recent New York School of Regional Anesthesia (NYSORA) world congress in Dubai, it would appear that the practice of regional anaesthesia without ultrasound (US) guidance seems irresponsible.

It is of utmost importance to always document details regarding medical procedures. The objective documentation of a regional nerve block is extremely important, not only to avoid an unwanted complication (albeit rare), but also for litigation purposes.

Regional anaesthesia is very effective in limiting the perioperative pathological stress response, alleviate pain and possibly improve outcome, although this remains a contentious point. Regardless of the debate around outcome, it still remains a very effective part of a multimodal analgesic regimen, even for day case surgery.¹

With regional techniques, complications can range from dramatic cardiovascular collapse during spinal anaesthesia to minor sensory loss after peripheral nerve blocks. The commonly cited incidence of complications after nerve block is 0-5%, bearing in mind that the aetiology of neurologic complications is often multifactorial. Although data suggest that complications are rare, the consequences of a lack of prevention strategies should remain a significant concern to both anaesthesiologist and patients alike.

Currently, no guidelines exist regarding the practice of peripheral nerve blocks.² This is mostly based on practitioner preference and subjective methods used to ascertain correct placement and avoidance of complications.

Despite the fact that the exact mechanism of nerve injuries remains speculative, it is well known that the main inciting factors are intrasaccular or intraneural injection.³ Knowing this, why do so many practitioners stubbornly cling to nerve stimulation (NS)? An inconvenient truth is that there are still no studies showing a consistent relationship between stimulating current and distance from the nerve.⁴ And, before advocates of NS wave the flag of academia, consider that there certainly seems to be enough evidence to suggest US improves success rates of all plexus blocks.⁵⁶

What about cost, then? Certainly, this is a very valid point. The initial financial layout when acquiring a US machine is large, no doubt about that. But, consider the fact that its use can eliminate the need for stimulating needles and NS altogether. A single shot block can be done with a simple 22G needle! Furthermore, it can be a very effective cost saving and revenue generating tool in the ambulatory setting.⁷

As an educator, I have a responsibility to recognise technology that improves the practice of our beautiful science. And I cannot believe that we still feel comfortable poking needles around delicate anatomical structure without real-time visualisation. It is, after all, the local anaesthetic that blocks the nerve, not the needle!

The training in the use of US and the availability of this technology in our country is of crucial importance to the future of regional anaesthesia practice. The last ten to twelve years has seen a dramatic increase in the use of US, which will continue to revolutionise the practice of regional anaesthesia.

It will soon be unacceptable to practice modern anaesthesia without the use of US.

Dr D Möhr
University of Pretoria

References