Reply

Dear Editor,

I thank the reader for noticing and appreciating our article “Major laparoscopic surgery under regional anaesthesia: A prospective feasibility study” published in *Med J Armed Forces India* 2015; 71:126–131.

Minimal access surgery especially laparoscopic surgery has really revolutionized the field of surgery especially in terms of post op morbidity. Anaesthesia had to rise up to the new challenges arising out of it. Earlier in the era of open surgeries the Anaesthesia had gradually advanced and most of those erstwhile ‘GA only’ surgeries were increasingly being done under regional Anaesthesia bringing in their own advantages and benefits. With advent of minimal access surgery, these surgeries slipped back into the ambit of ‘GA only’ area. Our attempt was to assess the feasibility of bringing them back into the regional Anaesthesia ambit. Some studies as pointed out by the reader have tried thoracic subarachnoid block but I think those attempts will still be called heroic and cannot be considered to be an approach which the masses can adopt.

The reader's concern regarding the Anti-Trendelenberg position required by the surgeon are genuine and we were also highly concerned about this when we started with the study and were very particular about preloading and were ready with Mephentermine or phenylephrine but as the study progressed we realized that practically problem was not that serious as we originally anticipated. With a preloading of one to one and a half litres the requirement of sympathomimetic was similar to any other surgery under Spinal Anaesthesia or CSE. The Gynaecologist as such operates in Trendelenberg and lithotomy position so the problem was there with them.

Regarding the muscle relaxation, the relaxation is excellent in CSE. The combined spinal as well as epidural Anaesthesia

give a widespread and dense block, so muscle relaxation is not an issue. Occasionally the surgeons had some issue of patient's breathing leading to movement of liver and other structures with movement of diaphragm and we couldn't offer them holding of breath at any crucial moment as in controlled ventilation but once gallbladder is held this problem is not much.

Regarding blood CO₂ levels. We didn't have the where-withal to do ABG so that parameter was not monitored but the end-tidal CO₂ levels remained within normal limits and no patient showed any sign of respiratory distress.

After doing this feasibility study we have realized that these surgeries can be safely done under regional Anaesthesia in any peripheral hospital with in the resources available in most of the peripheral hospitals, without any modification in surgical technique. After this study all the major laparoscopic surgeries are being done under CSE only and it has become the standard of care in our hospital.

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Letter to Editor

Dear Editor,

I read with great interest the original article titled “Comparative analysis of changes in MR imaging of pre and post intra uterine progesterone implants in adenomyosis cases” by Dashottar et al published in *Med J Armed Forces India* 2015; 71:145–151.¹ Being a practicing gynecologist I have few practical points to make.

It's a well known fact that MRI is a sensitive tool for diagnosing adenomyosis. However its role in monitoring the effects of hormonal therapy doesn't appear to be very sensitive and cost effective.

As per article, 50% of the post intra uterine implant cases showed reduction in the high intensity signals, whereas only 10% of the cases showed mild reduction in junctional zone thickness and there was no significant change in the uterine

size. However in the same time frame i.e. over 12 months, there was significant reduction in pain in 96% of cases and in menstrual blood loss in 94% of cases. In fact more than 60% of the patients got symptomatic relief in 3 months only.

So can it be presumed that speed of regression of MRI findings has got very little or probably no correlation with the speedy symptomatic relief of the patients? If this be so, can this be concluded that clinical follow up is cheaper, reliable and a sensitive modality of follow up of these patients. After all, the very purpose of any medical management in adenomyosis is purely symptomatic relief and not the cure.

What was the MRI finding of approximately 4%–6% of cases who did not respond to treatment? The article also doesn't mention about the evaluation modality of assessment of pain and menstrual blood loss to avoid observational bias.