initial few cases we were using single shot technique. After receiving this letter we did a number of cases under pure spinal anaesthesia with bupivacaine and fentanyl and had similar results as with CSE but it does call for further studies to confirm. The biggest problem faced during laparoscopic surgery under regional anaesthesia is shoulder tip pain because of diaphragmatic stretching especially if the initial peritoneal insufflation is too rapid. This pain is mediated

through C4 which can't be blocked either by CSE or EVE and we feel that this was considerably muted by intrathecal fentanyl but further larger comparative studies will be required to confirm this.

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Letter to the Editor

Dear Editor,

We read with profound interest the original article titled 'Real time ultrasound-guided percutaneous tracheostomy: is it a better option than bronchoscopic guided percutaneous tracheostomy?' by Ravi et al. published in *Med J Armed Forces India* 2015;71(2):158–164.¹ The study highlights the usefulness of ultrasound-guided percutaneous tracheostomy (USPCT) in assessing the vascular and soft tissue anatomy of the neck as compared to the bronchoscopic-guided percutaneous tracheostomy (BPCT).

We have the following queries:

- Was any percutaneous tracheostomy (PCT) performed in an unintubated case or an awake patient in the study?
- Use of local infiltration with Lignocaine with or without adrenaline before or during the procedure.
- Plausible reason for the statistically significant tracheal cuff puncture, 8 out of 36 cases in BPCT technique against 0 out of 38 cases in USPCT.

We would also like to express the following:

In our experience of twenty-four BPCT performed between August 2012 and July 2015 (Griggs technique – 10 and PercuTwist technique – 12), the only significant major complication we had was two cases of severe hemorrhage (<50 ml), both with the Griggs technique. Both cases were obese with short neck. As brought out by your article, availability of ultrasound guidance may have prevented the complications.

A study found the use of ultrasound combined with bronchoscopic examination very useful in enhancing the

safety of PCT. Ultrasound examination before and bronchoscopic surveillance during the procedure drastically minimized complications in PCT.²

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Reply

Dear Editor,

Thank you very much for the keen attention given to the article. I have replied to your kind queries to the best of my abilities and hope these replies will suffice.

- We did perform the percutaneous tracheostomy (PCT) in unintubated patient in few of the planned percutaneous tracheostomy in the ICU. However, we did not include it in our study since they were very few in numbers and it would have created a bias (as per the statistician) in the analysis.

- (b) We did not use local anaesthesia in any of the patients. We performed all PCTs under fentanyl and ketamine. We did infiltrate the skin incision area with saline before giving incision.
- (c) In fact, this finding was a surprise for us also. We deduced that the most probable reason was, since the removal of Endotracheal Tube (ETT) was done slowly (mm to mm) just below the vocal cords under bronchoscopic guidance.

This may have caused accidental puncture of the cuff. At no point of time we desired to come above the vocal cord. As it will be appreciated, it is very difficult to see the vocal cords through the endotracheal tube and identification of tracheal cartilage, especially in short neck and obese people. Further, it is not advised to have the balloon of ETT impinging on the cords. The margin of error off keeping the cuff just below the vocal cords and above the 1st or 2nd tracheal cartilage, especially in short neck and obese is less. Further, the sliding of the cuff is easily identified with US. Hence, our understanding is that it was entirely a technical issue; however, it has been reported that US-guided PCT might have an edge in obese patients in reducing cuff punctures¹; however, further studies are required to prove its efficiency.

We take tremendous pride in your study, especially the fact that you have used Percutwist, which is technically more challenging, specifically in obese patients. USG has an added

advantage in delineating the anatomy of the neck, particularly the vascular anatomy.²

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Letter to the Editor

Dear Editor,

I read with extreme interest the Original article titled “Uterine artery embolization for uterine fibroids: our experience at a tertiary care service hospital” by Dsouza et al. published in *Med J Armed Forces India* 2015;71:233–238.¹ Following observations are made:

1. The authors in their inclusion criteria have mentioned that all patients had regular menstrual cycles in last twelve months, whereas in the results it is shown that 88% of patients presented with menorrhagia. This discrepancy is not understood, as it is well known that the commonest symptom of fibroids is menstrual abnormalities.
2. The follow-up of six months is a short period to come to any conclusion about the recurrence of symptoms and need for hysterectomy at a later date, though this is brought out by authors in the limitation of their study.

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