Editor—To complement the excellent article by Drs Snaith and Dolan on ultrasound (US)-guided forearm blocks, we would like to point out the US visibility of the medial cutaneous nerve of forearm (MCNF), identifiable next to the basilic vein between MN and UN (Fig. 1), and posterior cutaneous nerve which is found on the prominence of the brachioradialis muscle (Fig. 2). Also the interosseous branch of the median nerve (MN) is clearly visible in Figure 4 of their article, running on the interosseous membrane along with the anterior interosseous artery. This nerve also supplies part of the wrist joint.

The authors mention the need for heavy sedation if multiple distal blocks are performed. We would disagree. In our institution, it has been common practice in the last 4 yr to block all peripheral nerves without the use of subcutaneous local anaesthesia. If performed with due technique, this causes little discomfort. A recent audit on tolerability has shown that 90% of patients experience little or no pain during insertion of the blocks.

**Declaration of interest**

None declared.

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**References**

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**Reply from the authors**

Editor—We thank Drs Jayakumar and Egeler for their interest in our article and their comments. The ultrasound description of the medial cutaneous nerve of forearm and posterior cutaneous nerve of forearm are well described. These peripheral nerves, which provide cutaneous sensation in the forearm, were not included in our article which focused on regional anaesthesia of the hand. We agree that the anterior interosseous nerve (AIN), although predominantly a motor branch of the median nerve (MN), also contributes to the innervation of the wrist capsule and periosteal nerve network. In addition to the superficial radial and ulnar nerves, the wrist capsule is also supplied by the palmar cutaneous branch of the MN which also provides articular branches to the joint. It is unlikely that the distal
block of the AIN alone will result in complete sensory blockade of that part of the wrist joint supplied by the MN. Therefore, wrist joint surgery necessitates blocking the MN proximally before it branches between the two heads of the pronator teres muscle.²

We also agree with Drs Jayakumar and Egeler that peripheral nerve blocks may be undertaken in the absence of sedation or without the subcutaneous infiltration of local anaesthetic. However, an intrinsic part of regional anaesthesia is appropriate sedation that helps to alleviate discomfort and maintain continued acceptance by patients.³ The results of the audit described by Drs Jayakumar and Egeler confirm that 10% of patients experience more than a little discomfort during peripheral nerve blockade. Therefore, we often use 1–2 mg midazolam in combination with 50–100 µg fentanyl when multiple distal peripheral upper limb nerve blocks are performed in the unpremedicated and often anxious day-case patient.

**Declaration of interest**

None declared.

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**References**

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