choice for prevention (71.2%) and treatment (49.6%) of emergence agitation, UK-based anaesthetists (58%) preferred propofol and opioids for prevention and would wait for spontaneous resolution (54.4%). Parental presence for treatment of emergence agitation was allowed in more than 60% in UK responses and more than 40% in Italian responses. The majority of Italian respondents (66%) discuss before operation the possible presentation of emergence agitation, while the majority of UK-based respondents would do so once delirium presents (46%). More than half of UK respondents identified sevoflurane as the primary cause of emergence agitation followed by pain, preschool age, and stormy mask induction, while the majority of Italian respondents gave pain as primary cause followed by sevoflurane, stormy mask induction, and the child’s temper. Prolonged crying and thrashing were considered the most important features for the diagnosis of emergence agitation in both countries.

The current survey reveals differences among European countries regarding the attitude towards, and management of, emergence agitation. However, the composition of the two paediatric societies, reflecting the degree of experience in the field of paediatric anaesthesia, makes a direct comparison difficult and any conclusions must, therefore, be drawn with great care.

The role of midazolam for emergence agitation remains controversial. While several studies report a reduced incidence of emergence agitation after midazolam premedication, others report no effect or an even increased incidence and longer lasting agitation. Treatment of emergence agitation depends also on the healthcare provider who assists the child during emergence from anaesthesia. Anaesthetists might be more prone to a pharmacological, rapid solution, while post-operative recovery nurses may choose to comfort and use parental presence to calm the child with emergence agitation. The third principal difference between respondents from the UK and Italy is timing of information given to parents. The amount of information given beforehand to the patient might depend on legal aspects of consent. Furthermore, the increasing numbers of civil claims may lead the Italian anaesthetist to a more cautious approach. Is emergence agitation to be considered as a complication of anaesthesia requiring preoperative discussion? This question and the role of midazolam (if any) for emergence agitation have to be addressed in the future.

Solution to the challenging part of the Shamrock method during lumbar plexus block

Editor—The ‘Shamrock method’ is considered to be the standard approach for lumbar plexus block. As Sauter and colleagues have described, the most challenging part of the Shamrock method is to start with a correct puncture angle to approach the plexus. Although we can puncture the skin according to the landmark-guided method (4 cm lateral to the midline in adults) with an absolute posterior–anterior needle direction, the plexus might be located higher or lower than expected. Therefore, there might be a need to redirect the needle either laterally or medially after skin puncture in order to approach the plexus. The more deviated the angle from the original, the lesser the possibility that the ultrasound beam will be reflected back to the transducer receiver; hence, the image would be poorer. In our opinion, the best way to avoid needle angling after skin puncture is to find a more accurate needle entry point to keep the needle trajectory (from skin puncture point to the plexus) almost always perpendicular to the ultrasound beam during Shamrock lumbar plexus block.

Our solution to the challenge is fine tuning the needle entry point instead of 4 cm lateral to the midline. Without changing the original posterior–anterior needle direction, the skin is punctured at the level targeting the centre of the postero-medial quadrant of psoas major muscle, where the plexus is expected to be encountered. The distance from the bottom of the transducer to the plexus obtained in the ultrasound image (Fig. 1a) could be applied to help minimize the chance of needle redirection. This needle entry point (Fig. 1a) is suggested to create the shortest distance from the skin to the plexus and at the same time optimize the needle shaft visibility for the Shamrock method. Compared with other

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The ultrasound visibility for psoas major muscle is also reported to be highest in average-weight adults, thus making it a reasonable target in clinical practice. This solution provides spatial information regarding how far away from the transducer we should insert the needle (Fig. 1B) and clearly addresses the most challenging part during Shamrock lumbar plexus block.

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Fig 1 The needle insertion point to keep its trajectory perpendicular to the ultrasound beam during Shamrock lumbar plexus block. By using the Shamrock method for lumbar plexus block, the distance from the bottom of the transducer to the plexus could be obtained in the ultrasound image (A), exactly the distance away from the transducer for the needle insertion within the emitting plane (B). EO, external oblique muscle; IO, internal oblique muscle; TA, transversus abdominis muscle; TP, transverse process. Blue star, the centre of the postero-medial quadrant of psoas major muscle. T, the horizontal line at the bottom of the transducer contacting the patient skin. N, the horizontal line at the level of the blue star.

Cut tracheal tube and GlideRite® Rigid Stylet

Editor—The use of cut tracheal tubes is a common practice in the UK. Despite the lack of firm scientific basis behind this practice, the purported benefits are decreased dead space and airway resistance, minimizing the risk of kinking and endobronchial intubation and facilitating endobronchial suction. GlideScope® (Verathon Inc., Bothell, WA, USA), one of the popular video-laryngoscopes, is commonly used with a reusable, purpose-built tracheal tube stylet, GlideRite® Rigid Stylet (Verathon Inc.).

Unlike the malleable stylets that can be shaped to accommodate cut tracheal tubes of various lengths, the GlideRite® stylet is non-malleable and is of fixed length. This means that the cut tracheal tubes cannot be used with the GlideRite® stylet, as this would result in the stylet protruding beyond the tip of the tracheal tube and can cause injury (Fig. 1). A possible solution to this would be to cut the tracheal tube after intubation, but this could be potentially hazardous.

We offer a simple and novel solution to this problem—the cut portion of each tracheal tube, which would be otherwise discarded, can be used as a ‘spacer’ (Fig. 2) to fill up the extra space. This would ensure that the stylet will always remain cross-sectional anatomic and magnetic resonance images. Reg Anesth Pain Med 2013; 38: 391–7
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