

with certain clinical scenarios, can make it extremely challenging to place a left DLT in some patients.⁴ This difficulty arises in cases of significant left tracheal deviation, where the left DLT naturally tends to shift to the right. We increasingly encounter this challenge, particularly in patients with a history of left pulmonary resection (as a lower left lobectomy often leads to right tracheal deviation) or tracheomalacia. In such cases, catheterizing the left mainstem bronchus using a fiberoptic scope or an endotracheal tube introducer is an option, but it is time-consuming and can pose risks such as tracheal or bronchial perforation.⁵ Considering the rapid use of a right DLT probe may therefore be helpful (Supplementary Digital Material 1: Supplementary Video 1, 29.5 MB, 51 s).

Our experience suggests that such cases are becoming increasingly common, and we hope that this letter will encourage anesthesiologists and surgeons to consider this option in similar situations.

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References

1. Benumof JL, Partridge BL, Salvatierra C, Keating J. Margin of safety in positioning modern double-lumen endotracheal tubes. *Anesthesiology* 1987;67:729–38.
2. Bussi eres JS, Lacasse Y, C  t   D, Beauvais M, St-Onge S, Lemieux J, *et al.* Modified right-sided Broncho-Cath double lumen tube improves endobronchial positioning: a randomized study. *Can J Anaesth* 2007;54:276–82.
3. Pedoto A. How to choose the double-lumen tube size and side: the eternal debate. *Anesthesiol Clin* 2012;30:671–81.
4. Russell WJ. A logical approach to the selection and insertion of double-lumen tubes. *Curr Opin Anaesthesiol* 2008;21:37–40.
5. Zhang X, Wang DX, Wei JQ, Liu H, Hu SP. Recent advances in double-lumen tube malposition in thoracic surgery: A bibliometric analysis and narrative literature review. *Front Med (Lausanne)* 2022;9:1071254.

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Authors' contributions

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Serratus posterior superior intercostal plane block + quadroiliac plane block for scoliosis surgery: two novel blocks away from the surgical field

We have read with great interest the articles by Ciftci *et al.*¹ entitled “Serratus posterior superior intercostal plane block: novel thoracic paraspinal block for thoracoscopic and shoulder surgery” and Turan *et al.*,² entitled “Efficacy of quadro-iliac plane block in single level lumbar discectomies: a case series for novel block.” Ciftci *et al.* reported that serratus posterior superior intercostal plane block (SPSIPB) can be used as an analgesic block in patients undergoing thoracic surgery. We thought that SPSIPB could be effective as an analgesic in vertebral surgery in the thoracic region due to its spread in the erector spinae and rhomboid muscle plane, as it is a periparavertebral block. The quadroiliac plane block (QIPB) is a novel interfascial plane block technique that provides lumbar, lower abdominal, and hip analgesia. Turan *et al.* performed quadroiliac plane block (QIPB) in five patients who underwent single-level lumbar discectomy surgery. They reported that pain scores and opioid requirements were low during the postoperative period. According to these clinical experiences, we performed QIPB + SPSIPB in a patient who underwent magnetic controlled growth rods scoliosis surgery. Herein, we want to share our clinical experiences about bilateral QIPB and SPSIP blocks for magnetic-controlled growth rod scoliosis surgery. Written informed consent was obtained from the patient’s parents for the publication of this report.

A 7-year-old, 35 kg female patient developed paraplegia after a traffic accident that occurred three years before. Direct radiographs showed 60-degree curvature.

The main purpose in the treatment of early-onset scoliosis is to keep the deformity under control until adequate spinal development is achieved.³ For this reason, magnetically controlled rod application between T1-T2 and L4-L5 vertebrae levels and iliac bone was planned for our patient (Figure 1). The patient underwent surgery under general anesthesia with an ASA-III risk score. We performed her 500 mg paracetamol IV two hours before the end of surgery for multimodal postoperative analgesia management. Since the surgery was in both the thoracic and lumbar regions, we planned to perform SPSIPB and QIPB for pain relief. At the end of surgery and before extubation, bilateral SPSIPB (totally 30 cc 0.125% bupivacaine) and bilateral QIPB (totally 30 cc 0.125% bupivacaine) were applied. For QIPB, while the patient was in prone position, we placed a sterile convex probe sagittally at the point where the quadratus lumborum muscle (QLM) attaches to the iliac crest (IC). At this point, the erector spinae muscle (ESM) and the QLM below it were visualized. The needle was advanced in a craniocaudal direction towards the IC. The block location was confirmed by administering 5 mL of isotonic solution at the point where the QLM attaches to the IC. Then, local anesthetic (LA) was injected. The spread of the LA between the ESM and the QLM was observed. For SPSIPB, the linear transducer was placed on the third rib, just near the medial border of the scapula at the level of the spinae scapula. The needle was inserted just above the third rib, deeply into the serratus posterior superior muscle (SPSm). After confirmation with isotonic saline injection, LA was administered between SPSm and the third rib. We administered 500 mg of paracetamol IV every 8 hours postoperatively. During the postoperative period, the numerical rating score did not exceed four, no extra analgesic was administered, and there was no need for opioid agents at the postoperative period.

The most important advantage of SPSIPB and QIPB for vertebral surgeries is that the application area is far

away from the surgical region and local anesthetic distribution is not affected by surgical trauma. According to our experiences, SPSIPB and QIPB may be effective alternative analgesic methods for scoliosis surgery.

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References

1. Çiftçi B, Alver S, Ahiskalioglu A, Bilal B, Tulgar S. Serratus posterior superior intercostal plane block: novel thoracic paraspinal block for thoracoscopic and shoulder surgery. *Minerva Anestesiol* 2024;90:345–7.
2. Turan EI, Aslan C, Berber K, Sarban O, Şahin AS. Efficacy of quadro-iliac plane block in single level lumbar dis-

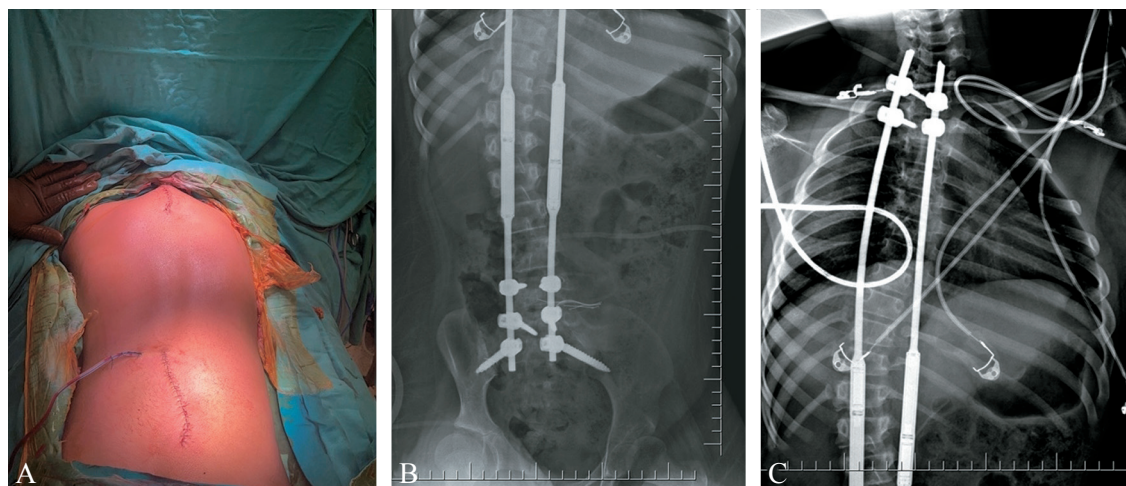


Figure 1.—Surgical field and X-ray images of rods: A) surgical incisions and drain; B) posterolateral X-ray image of instrumentation; C) anterior X-ray image of instrumentation.

cectomies: a case series for novel block. *Minerva Anestesiologia* 2024;90:1159–60.

3. Tsirikos AI, Roberts SB. Magnetic controlled growth rods in the treatment of scoliosis: safety, efficacy and patient selection. *Med Devices (Auckl)* 2020;13:75–85.

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Authors' contributions

All of the authors made substantial contributions to the conception and design, or acquisition of data, or analysis and interpretation of data; they have been involved in drafting the manuscript or revising it critically for important intellectual content; and they have given final approval of the version to be published.

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Bilateral cervical plexus block in a pediatric patient undergoing thyroglossal duct cyst excision

Thyroglossal duct cysts are the most common congenital cystic anomalies of the neck, accounting for more than 75% of midline neck masses in childhood. These cysts can develop anywhere along the thyroglossal duct tract, from the foramen cecum at the base of the tongue to the suprasternal notch.¹

Regional anesthesia plays a significant role in a multimodal approach to postoperative pain management, and peripheral nerve blocks offer effective analgesia. In pediatric patients, it is particularly important to provide optimal pain control by minimizing opioid use. This case highlights the successful use of bilateral cervical plexus

block for postoperative analgesia in a pediatric patient undergoing thyroglossal cyst excision. This technique, which is underused in pediatric patients, may offer an effective alternative for postoperative analgesia in the pediatric group to avoid the side effects of systemic analgesics.

Different techniques and depth levels have been proposed for cervical blocks. Briefly, they can be divided into superficial and deep cervical plexus blocks.² Due to the risk of complications, deep cervical plexus blocks are no longer preferred; the sensory branches of the cervical plexus can be blocked with a superficial block. The four superficial branches of the cervical plexus are known to anastomose with various cranial nerves and sympathetic nerve fibers. The superficial cervical plexus emerges behind the posterior border of the sternocleidomastoid (SCM) muscle and innervates the head, neck, and the skin above clavicle.³

Superficial cervical plexus block is a well-defined regional anesthesia technique that is successfully used in neck surgeries. Local anesthetic is injected into the sensory branches of the C2–C4 nerve roots that innervate the neck.⁴ Although the sensory nerves are targeted with the superficial block, the phrenic nerve may also be blocked due to high-volume injection.⁵ Therefore, high volumes should not be used in bilateral block applications. The sensory branches of the cervical plexus are structurally small nerves with low connective tissue content, making it difficult to clearly distinguish individual nerves using ultrasound.⁶

On the other hand, the structural characteristics of the nerves increase their sensitivity to local anesthesia, allowing for the use of local anesthetic at lower volumes and concentrations.⁴ Additionally, the spread of the drug can be monitored in real time with ultrasound, thereby ensuring the proper distribution of the local anesthetic used at lower volumes, which increases the success rate. The use of regional techniques in the pediatric population is based on reducing opioid use in pain management. The use of regional techniques may support faster recovery and more comfortable awakening in postoperative pain management by reducing opioid use. In a retrospective study comparing the effectiveness of cervical plexus block in the pediatric population, it was stated that opioid use decreased.⁷

Complications that may develop after regional anesthesia cause more concern in the pediatric patient group. When the proximity of the cervical plexus block to anatomical structures is evaluated, it has been stated that the block application may cause some complications SUCH as hematoma, intravascular injection, LAST. The use of ultrasonography in block application allows avoiding vascular structures and at the same time, the spread of the local anesthetic allows the blocker to apply the local anesthetic dose to the effective area.⁶

A 5-year-old 105 cm 19 kg ASA 1 patient with an unremarkable medical history who was scheduled for elective thyroglossal cyst excision surgery. A cervical plexus block was planned for perioperative and postoperative analgesia before the surgical procedure, following the induction of general anesthesia. The family