

ated in ICU,⁴ explicitly accepting an off label use of this drug.

Definitely, we agree that EMA's PRAC indications have to be respected, but also wisely interpreted and applied with careful attention: for the home therapy or in the general hospital ward, it is correct to avoid daily doses higher than 100 mg. In critically ill, monitored patients without risk factors, an initial Hydroxyzine daily dose up to 600 mg⁵ appears adequate to reduce their "total proarrhythmic" risk, provided that the exposure is reduced with the earliest reduction/interruption of the administrations. This attention is anyway mandatory for all sedatives! For other patients, reducing the initial daily doses to 300 or 100 mg seems to be the most adequate strategy.⁶ Since in ICU there are not free-from-risk drugs or procedures, intensivist physicians (and hospital pharmacists) should avoid *a priori* stated, fundamentalist positions based on recommendations addressed to general practitioners.

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The association between the ultrasound-guided Serratus Plane Block and PECS I Block can represent a valid alternative to conventional anesthesia in breast surgery in a seriously ill patient

Dear Editor,

The recent introduction of pectoral nerves block (PECS block)¹ and Serratus Plane Block (SPB)² in breast surgery, represents an alternative to general anesthesia and locoregional conventional techniques,³ like epidural anesthesia or paravertebral block⁴⁻⁹ in oncological breast surgery, especially in high anesthetic risk patients, like in elderly women.¹⁰

The combination of SPB with PECS I block can provide a high-quality analgesia after modified radical mastectomy, as suggested by Bouzinac *et al.*¹¹

In our University Hospital of L'Aquila (Italy), the association between SPB and PECS I block was performed in a 78-year-old woman underwent to radical mastectomy and axillary dissection. She was 162 cm tall, weighed 80 kg (BMI 30.48, ASA III) and affected by a severe respiratory insufficiency for pulmonary fibrosis (in therapy with CPAP ventilation) heart failure (Ejection Fraction 32%), arterial hypertension, diabetes II type and renal chronic insufficiency. The patient needed of dual antiplatelet therapy. Written informed consent was obtained from the patient.

Regional anesthesia was performed under ultrasound-guidance; to realize Serratus Plane Block a 12.5 Mhz linear probe was positioned at fifth rib, along the middle axillary line. The in-plane approach was used and after that the interfascial plane between *latissimus dorsi* and *serratus anterior* muscles was identified, 3-4 mL of saline solution were injected to open this fascia, and then a total of 25 mL of 0.5% Levobupivacaine solution were injected (Figure 1).

PECS I Block was performed by injecting in the fascia between minor and major pectoral muscles, 10 mL of 0.375% Levobupivacaine (Figure 2). An ipsilateral parasternal injection under ultrasound guide, was performed at 2nd and 4th intercostal space, in the external intercostal membrane between major pectoral and intercostal muscles. Two injections of 5 mL of 0.375% Levobupivacaine were performed.

A sedation with easy arousability was ensured with 3-4 mg/kg/h of intravenously propofol. Supplemental oxygen (8 L/min, 40% of inspired fraction of oxygen) is administered by Venturi mask under end tidal CO₂ control (ETCO₂) to ensure an Oxygen saturation (O₂Sa%) major than 90%; heart rate, ECG, arterial blood pressure and O₂Sa% were monitored during the surgery. A good quality anesthesia of the mammary and axillary regions was obtained, with a good hemodynamic stability and without

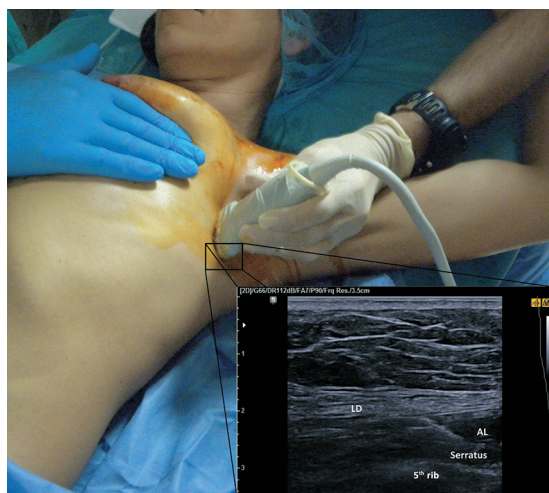


Figure 1.—Ultrasound-guided Serratus Plane Block. LD: latissimus dorsi muscle; AL: local anesthetic; Serratus: serratus anterior muscle; 5th rib: fifth rib.

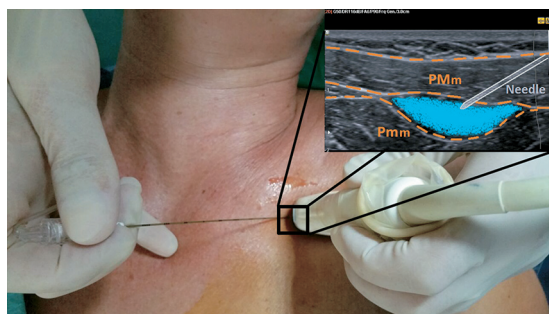


Figure 2.—Ultrasound-guided PECS I Block. PMm: pectoral major muscle; Pmm: pectoral minor muscle.

discomfort for the patient and surgeon; so at the end of surgical procedure, the infusion of propofol was stopped and the patient was admitted in PACU phase 1 and then in PACU phase 2, according to the PACU policy.¹²

The association between SPB, PECS I block and parasternal LA injections, ensured a good quality and a long lasting analgesia. In the first 24 hours after surgery, the patient did not request opiates, and only 2000 mg of acetaminophen were administered.

This experience shows that, although the epidural and paravertebral thoracic block represent the gold standard in breast surgery⁴⁻⁹ the hypothesis of Bouzinac *et al.*¹¹ about the analgesic efficacy of the association between SPB and PCS I block, could be true.

This case report could suggest the idea that the combination between these two anesthetic procedures could have a good anesthetic potency and be a valid alternative to conventional techniques, especially in high anesthetic risk patients undergoing breast cancer surgery.

Further studies should be needed to demonstrate the validity of SPB and PECS I block as an anesthetic standardized method for breast cancer surgery.

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