

Respond to: Comparison of sonographic inferior vena cava and aorta indexes during fluid administered in children



This study was conducted prospectively in South Korea.

There are so many children who come to the pediatric emergency department who really don't need IV hydration.

It was hard work and the recruitment rate was very low for the enrollment of 34 children who need IV hydration during the emergency physician's working time, who has the certification of the ultrasound imaging and teaching.

The patients who were in life-threatening shock were excluded because those patients were sorted to the critical pathway in the PED.

And, it is hard to define hypovolemic shock in children.

This study was conducted in the PED, not in the ICU for the evaluation of Ao/IVCA and other indexes, not for the preload. Ao/IVCA might be related to preload, however, we could not perform the study related the preload because the common children with AGE might don't need the invasive or critical monitoring in South Korea.

Thank you for your comments.

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Ultrasound-guided erector spinae plane block for acute herpes zoster pain management: Is it safe?



Dear Editor,

We read with great interest the case report titled "Ultrasound-guided Erector Spinae Plane Block for Acute Herpes Zoster Pain Management," by Tekin et al. [1] We applaud the authors' efforts in controlling pain during its devastating acute phase, and we agree that a number of randomized controlled trials are needed to determine the efficacy of this approach in comparison to conventional methods of pain management. However, a few questions come to mind regarding the efficacy, duration of action, and safety of the block, which may need to be addressed before drafting a study protocol.

First, over 90% of a pooled review of 242 cases showed that an erector spinae plane block (ESPB) was used as part of a multimodal analgesia regimen [2]. Thus, our question is, what other methods of analgesia were used with their ESPB technique during a follow-up period of up to one month?

Second, earlier studies have shown that beyond the initial duration of complete analgesia for 12–36 h, patients with continued, post-herpetic neuralgia continue to need additional boluses or a continuous infusion by catheter [3,4]. We are thus curious if there are any other details that the authors can provide to explain a month of sufficient pain control (3/10) from a single, initial shot of ESPB.

Finally, in regards to safety, the disease is highly contagious, and most patients with Varicella-zoster virus reactivations are immunocompromised. According to text books [5] and our clinical experience, the pictures in the case report show that the skin eruptions covered the T2 region and, quite possibly, the T3 region as well, despite the authors mentioning the dermatomal coverage as T1. The authors also mentioned the needle insertion level as T2/3. However, injecting a possibly infected skin area during the eruptive phase could increase the risk for auto-inoculation into deep areas or viremia that could lead to life

threatening dissemination of the infection. What precautions should be taken into consideration before injection?

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Ultrasound guided erector spinae plane block as a safe and effective method to treat herpes zoster pain



Dear Editor;

We thank readers for interest in our manuscript entitled with "High-thoracic ultrasound guided erector spinae plane block for acute herpes zoster pain management in emergency department" [1]. We also