provide two ultrasound videos, performed in two different patients, in both short and long axis view showing the proximal spread of local anaesthetic after the injection of 10 ml at the apex of the femoral triangle (Supplementary Data S1 and S2).

In conclusion, we think that the continuity of the bubble signs along the thigh well demonstrates the anatomical continuity between the femoral triangle and the adductor canal. In addition, we consider dynamic evaluation of the craniocaudal spread of the injectate by ultrasonography as the most reliable method to obtain a safe and effective block. The block categorisation suggested by the authors best suits this new conception that the adductor canal is no more a conundrum, but rather a continuum.

Declarations of interest

The authors declare that they have no conflicts of interest.

Supplementary material

Supplementary video related to this article can be found at https://doi.org/10.1016/j.bja.2020.04.018

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Effect of intraoperative PEEP and recruitment manoeuvres on postoperative lung aeration. Comment on *Br J Anaesth* 2020; 124: 101–109

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Keywords: atelectasis; inspired oxygen; positive end-expiratory pressure; recruitment manoeuvre; zero end-expiratory pressure

Editor—I read with interest the publication by Généreux and colleagues.[1] It reports that the degree of aeration loss after tracheal extubation was similar between groups receiving either PEEP and recruitment manoeuvres (RM) or zero end-expiratory pressure intraoperatively, although intraoperative aeration loss was less in the PEEP/RM than in the zero end-expiratory pressure group. Some factors might have modified the findings.

First, all patients had initially received the intermediate-acting neuromuscular blocking agent rocuronium. Supplemental intraoperative dosing of rocuronium does not seem to have been guided by neuromuscular monitoring. In the absence of such monitoring, residual neuromuscular block after the administration of fixed doses of neostigmine and glycopyrrolate before emergence from anaesthesia cannot be ruled out. As residual neuromuscular block is associated with impaired postoperative lung function and postoperative pulmonary morbidity,[2,3] a modifying effect on the findings cannot be ruled out.

Second, before tracheal extubation, patients in the PEEP/RM group were spontaneously breathing for a median time of ~2.5 min, individual patients for up to 5 min. There is no indication that the intraoperatively applied PEEP of 7 cm H_2O was maintained during this period of time up to the moment of tracheal extubation. Acute withdrawal of PEEP at a time of resumption of spontaneous respiration in the presence of increased airway resistance caused by the tracheal tube might have facilitated formation of atelectasis.

Finally, there is no information regarding the inspired oxygen fraction (F_IO_2) during spontaneous respiration before

tracheal extubation. An F_IO_2 of 1.0 was associated with more post-extubation atelectasis and poorer oxygenation compared with extubation at a lower F_IO_2.[4] Possible use of an F_IO_2 of 1.0 at the time of spontaneous respiration before extubation might also have facilitated formation of atelectasis. As all of these factors (i.e. residual neuromuscular block, withdrawal of PEEP during spontaneous respiration, F_IO_2 of 1.0 before tracheal extubation) might have obscured or even negated treatment effects and differences between groups; clarification of these issues is needed to allow reliable conclusions.

Declarations of Interest

The author declares that they have no conflict of interest.

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