**INTRODUCTION**

Pediatric regional anesthesia continues to evolve. Education and attention to anatomical detail remain key elements to successful outcomes. New techniques, some adapted from adult practice, provide analgesia for pediatric surgical procedures such cleft palate or congenital hip dysplasia. [1, 2]

Congenital cleft palate (CP) occurs in children at a rate of about 1.5 per 10000 births, requiring early surgery, during the first months of life. The surgical procedure can be complicated by airway obstruction and respiratory complications. Administration of opioids, often needed for intra- and postoperative analgesia, increases the risk of airway obstruction and promotes ventilatory control dysfunction. CP is painful in the first 24–48 h following surgery. Morphine is usually used for postoperative analgesia, and as a consequence, a minimal 24-h stay in the recovery room or intensive care unit is often necessary. Recently there is an increasing awareness regarding the need for complete well being of the child in the postoperative period and not just a pain free state. [3, 4]

Sedation and other adverse events produced by opioids do not help in achieving such a goal. Local anesthesia with nerve blocks appears to be the answer in such circumstances. Moreover, regional and general anesthesia techniques are no longer considered as alternative but instead, as complementary. This is especially true in pediatrics where regional anesthesia is essentially performed under general anesthesia. The association of the two techniques has dramatically cut down the risks of both procedures. **Steven C. Hodges** and **Andrew M. Hodges**[5] while reviewing anesthesia for cleft surgeries stated that opioids are better avoided, and intraoperative and postoperative analgesia can be achieved by local infiltration with local anesthetics or by nerve block.