⌂ Letters to the Editor

The Single-Needle Facet Joint Medial Branch Block Technique

To the Editor:

Nonradicular low back pain can be difficult to diagnose. Medial nerve branch blocks can aid in the diagnosis, but there is no consensus on how to perform these injections. The article by Stojanovic et al[1] is an excellent and timely study. Medial branch blocks using a single-needle technique are an important new tool for the diagnosis of facet joint arthropathy. The most commonly used technique mentioned by these investigators involves multiple needle placements for each nerve blocked. This multiple-needle technique may require a large amount of local anesthetic for anesthetizing the skin, thereby increasing the rate of false-positive blocks.

I would like to add 2 additional facts. Some physicians anesthetize not only the skin but also the fascia and muscle. A large number of false-positive median branch blocks are noted when the muscle and fascia over the facet joint are anesthetized with local anesthetic from the skin down to the facet joint area.[2] As a result, pain relief may be a result of a trigger point injection and not a result of a median nerve injection. The single-needle technique mentioned by the authors, which anesthetizes only the skin, should eliminate this confounding factor.

Furthermore, their article can be instrumental in elevating physician cost consciousness. Medicare recently mandated a double-comparative local anesthetic blockade for the performance of diagnostic facet joint injections. Medicare and other insurers believe that there are too many false positives with a single diagnostic injection and require a second diagnostic injection with a different local anesthetic before proceeding to denervation. The requirement of a second injection delays definitive treatment and may not always be cost-effective. The single-needle technique described by Stojanovic et al[1] could ultimately eliminate this requirement.

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References

1. Stojanovic MP, Dey D, Hord ED, Zhou Y, Cohen SP. A prospective crossover comparison study of the single-needle and multiple needle techniques for facet-joint medial branch block. *Reg Anesth Pain Med* 2005;30:484-490.
2. Ackerman WE, Munir MA, Zhang JM, Ghaleb A. Are diagnostic lumbar facet injections influenced by pain of muscular origin? *Pain Pract* 2004;4:286-291.

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Reply to Dr. Ackerman

To the Editor:

We agree with Dr. Ackerman that the use of large volumes of superficial anesthetic is a potential cause of false-positive medial branch blocks because of the inadvertent treatment of myofascial pain. Our previous study[1] and the reference cited by Dr. Ackerman correctly allude to this possibility. We would also like to emphasize that more studies are needed to prove this hypothesis.

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Reference

1. Cohen SP, Larkin T, Chang AS, Stojanovic MP. The causes of false-positive medial branch blocks. *Mil Med* 2004;169: 781-786.

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Total Spinal Block via a Subdural Catheter

To the Editor:

The case report by Wills[1] has provided useful new information regarding the dura–arachnoid interface and cases of subdural block. He described the collapse of a parturient within 2 minutes of the injection of 5 mL of 0.25% bupivacaine through a catheter accidentally inserted into the subdural space. His patient was unresponsive, apneic, and pulseless but responded well to resuscitation.

Although Wills[1] stated that the clinical picture "was consistent with a high subarachnoid block," he labeled this case as one of massive subdural anesthesia, although subdural block has a very different presentation. Wills[1] described the signs of a characteristic subdural block in a list that appears to have been copied from a previous communication of mine,[2] without any attribution. The onset of subdural block is delayed, slow, and gradual with only a moderate fall in blood pressure being evident. Gradual respiratory depression, not sudden apnea, may be a late feature.