Letters to the Editor

Interventional Techniques in the Management of Chronic Pain: Part 2.0

To the Editor:

I am writing to comment on Interventional Techniques in the Management of Chronic Pain: Part 2.0, published in the January issue of *Pain Physician*.

Evidently the philosophy of the society is definitely to provide a framework that can be applied to the practice of pain medicine from an interventional point of view.

Given the large and varied numbers of providers in the speciality of pain, a treatment consensus has been difficult to establish for any given type of pain.

The authors have dedicated an enormous amount of time to collect data, references and perhaps even anecdotal information about the management of pain syndromes.

It is only by efforts like this that the practice of pain medicine can reach some respect from our medical colleagues, and most importantly, from third party payers.

The insurance industry looks at pain with some degree of skepticism, this the result of having so many specialties participating in the management of patients with chronic pain without any direction or guidance.

The future of our speciality lies most certainly in the prac-

tice of evidence based medicine, which is what ASIPP is trying to achieve by this effort.

The authors of this document are to be commended for their dedication, interest and passion to improve the quality of pain medicine and in particular, interventional pain medicine.

I would recommend that a presentation be prepared that can be delivered to professional groups in specialties related to pain medicine, and of course to representatives of the insurance industry. This could represent an important educational motion, which will eventually result in better practice parameters.

Sincerely,

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Effect of Sedation on Validity of Diagnostic Facet Joint Injections

To the Editor:

I enjoyed reading the April issue of *Pain Physician*.

Manchikanti et al's article Contribution of Facet Joints to Chronic Low Back Pain in Postlumbar Laminectomy Syndrome: A Controlled Comparative Prevalence Evaluation (*Pain Physician* 2001; 4:175-180) was interesting. However, the authors used sedation with the block. There was a paper presented at the International Spinal Injection Society (ISIS) on the high false positive rate for facet nerve injection if sedation is used. I have had this experience. I used to give most patients 2 mg midazolam and 100 mcg of fentanyl for such injections. However, a man with post

op axial pain came in for medial branch blocks. Each time we used sedation. Each time we looked at his lumbar range of motion standing before and after the block. Prior to block he could stoop forward about 30 deg with pain and extend minimally. Post block he could touch the floor and extend nicely. He went on to rhizotomy but failed to improve. I brought him back and just gave the sedation without any block. His range of motion and pain reports were identical to the differential local anesthetic blocks. I would therefore propose that these studies may need to be repeated in one of two ways; without sedation, or with placebo when sedation is used.

Personally, I would prefer to give mild sedation to these patients. Perhaps propofol would be better as it is quick on and off. Midazolam hangs around too long and has benzo effect on muscle tone.

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In Response:

We appreciate the comments of Dr. Jasper. It is interesting to note that the same reference was communicated to the undersigned by another interventional pain physician. However, I was unable to find this publication mentioned in the ISIS newsletters and it has never been published in any peer review literature. At the present time, we are in the process of designing a protocol to evaluate the effect of 2 mg of midazolam compared to placebo in decreasing

pain and increasing activity status.

However, in this study only low dose midazolam was administered and no fentanyl or propofol was administered. Obviously, fentanyl could cause significant analgesia, however, I am not quite sure if midazolam will have an analgesic effect even though it may have muscle relaxant effect.

We do not believe that the studies need to be repeated just because we used a small dose of midazolam to sedate the patients. As Dr. Jasper mentions, it is preferable to give mild sedation to these patients. We are not comfortable to provide with the use of analgesia for simple procedures such as facet joint nerve blocks. Cost also may become a factor. We have not observed any significant side effects with midazolam.

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Algorithms for Interventional Techniques in Chronic Pain

To the Editor:

I would like to comment on some aspects of recently published algorithms for diagnosing and treating back pain entitled Interventional Techniques in the Management of Chronic Pain: Part 2.0 by Manchikanti L, Singh V, Kloth D et al (*Pain Physician* 2001; 4:24-96). There was placement of discography prior to lumbar facet injection. I believe that this should be changed. Lumbar facet injection may be done prior to lumbar discography and in most instances may be preferable to that. Perhaps, in the algorithm it should be redrawn so that in the decision making process, whether you are going to a discogram or a facet injection, could be decided based upon clinical exam rather than making it an absolute algorithm to first do a discography and then facet injection if necessary.

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In Response:

We appreciate comments by Dr. Prunskis. However, we believe that this is a misunderstanding on his part. All the algorithms clearly state that these are suggested algorithms for the application of interventional techniques in the conservative care of chronic spinal pain. Thus, there is no absolute algorithm to first do a discography and then a facet joint injection if necessary.

As stated in the abstract, these guidelines do not constitute inflexible treatment recommendations. It is expected that a provider will establish a plan of care on a case-by-case basis, taking into account an individual patient's medical condition, personal needs, and preferences, and the physician's experience. Therefore, based on an individual patient's needs, treatment different from that outlined here could be warranted.

We reviewed both the algorithms, figures 3 and 4, once again for the purpose of clarification. We are printing here enlarged algorithms as figure 3a & 3b for figure 3 and 4a & 4b for figure 4. Figure 3, which shows a suggested algorithm for the application of interventional techniques in the conservative care of chronic spinal pain: figure 3a