

■ CORRESPONDENCE

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Adverse Reactions to Nonindicated Medications

To the Editor:—We read with interest the informative and honest case reports by Fishman *et al.*¹ concerning corticosteroid-induced mania after single applications of 100 mg of triamcinolone at the celiac plexus. The authors correctly indicate that corticosteroids can be associated with mental status changes, including mania and psychosis, and cite multiple references documenting this effect. The two patients reported had a history of mania from previous corticosteroid use and had repeat manic episodes with the depot steroids injected by the authors.

What concerns us is the use of medications without real benefit for which patients have a documented history of adverse reactions. Data concerning the use of corticosteroids as an adjunct in celiac plexus blocks for chronic pancreatitis are meager at best. Of the two references cited by Fishman,² one is a single case report. The other article is a report of the use of depot steroids for chronic pancreatic pain in 16 patients, of which only 4 reported pain relief.³ The two patients reported by Fishman *et al.* had histories of adverse reactions to previously administered corticosteroids, including one after a single intraarticular injection.

Although, as the authors state, the prognosis of corticosteroid-induced neuropsychiatric complications is good, it is not something to be considered lightly. One of the patients signed out of the hospital against medical advice (AMA), and the other was found at some distance from her hospital room after the onset of the mania. Fortunately, these patients had no apparent significant residual morbidity. However, the outcome of some psychiatric patients discharged AMA is poorer than those discharged with medical advice.⁴ Certainly, the two patients reported on by Fishman *et al.* demonstrated lack of self control and poor decision-making during the 6 or 7 days it took for the mania to resolve.

As pain management anesthesiologists ourselves, we, like the au-

thors, frequently prescribe and inject medications for purposes that have not been proven to be completely safe and efficacious in prospective clinical trials. It is the nature of the subspecialty that we should weigh the risks and benefits of a possible treatment and proceed from there. However, we disagree with injecting drugs with questionable benefit for which patients already have a history of adverse reactions.

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In Reply:—We appreciate the comments of Sternberg and Cross and agree that clinicians faced with failed therapies for chronic conditions often rely on interventions that make theoretical sense but which may not have proven efficacy. This is certainly the case with pain from chronic pancreatitis.

We recognize that proceeding with local anesthetic and corticosteroid celiac plexus blockade requires consideration of the potential risks and benefits. In patients with history of corticosteroid sensitivity, the decision to proceed involves consideration of the potential for pain relief and the risks from mania, if it were to develop, and the likelihood of its successful management. Our cases suggest that mania can be a serious complication of corticosteroid usage from any regional procedure. In some cases, potential mental status changes may limit therapy, although if managed closely, mania can be self-contained and transient, perhaps even prevented with pre-treatment with mood-stabilizing agents.

Adverse reactions from corticosteroids, even in patients with history of adversity to these agents, is not assured. When they occur, they usually are transient and manageable with conventional therapy. Arguing the efficacy of corticosteroid injections at the celiac plexus was beyond the scope of our presentation. Our experience has been that a minority of patients have markedly beneficial responses with corticosteroid injections at the celiac plexus, and others have no benefit. Short of chronic opioid therapy, with its set of risks and benefits, this procedure may be the last resort for some patients with chronic pain from pancreatitis. For some, the risk of transient and manageable adverse effects in exchange for possible, albeit unproven, benefit from a procedure with otherwise modest risk, is an acceptable choice.

It is an unfortunate reality of contemporary medicine that we often do not have data to clearly justify many of the treatments that are routinely used. Although we strive to improve our supporting data,

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we often are faced with balancing the lack of scientific proof with experience, clinical judgment, and compassion.

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An Alternative Needle Geometry for Interruption of the Ganglion Impar

To the Editor:—The ganglion impar, also known as the ganglion of Walther, lies in the retroperitoneal space at the level of the sacrococcygeal junction. It is a solitary structure representing the fused terminus of the paired, paravertebral sympathetic chains. Interruption of the ganglion, first described in 1990 by Plancarte *et al.*,¹ has been an approved treatment for managing intractable, sympathetically mediated, perineal pain.

The approach used, as described by Patt and Plancarte,² involved lifting a skin wheal over the level of the anococcygeal ligament and advancing a needle to the retroperitoneal space under fluoroscopic guidance. Radiopaque dye was instilled to confirm final needle position. Traditional 22-gauge, 8.89-cm spinal needles, single- and double-bent as advocated in previous techniques, were initially used, although because of difficulties encountered during placement, an alteration of needle geometry was required.

Our initial patient, a 41-yr-old woman with squamous cell carcinoma of the anus, suffered unremitting burning pain along the anorectal column after radiation therapy. Difficulty in placing the needle was attributed to fibrosis along the needle path. However,

by bending the needle to the shape of an arc (fig. 1), thus removing any angulation, we were more easily able to navigate the curvature of the presacrococcygeal (postrectal) space (fig. 2). A local anesthetic blockade was accomplished without complication. At a later date, the patient received a successful neurolytic block in a technically easier procedure using the curved needle.

Our second patient, a 23-yr-old man who developed anorectal, burning pain after a gunshot wound to the pelvis, was successfully blocked with the curved needle while using a second needle to identify the bony coccyx.

The major advantage of the curved needle is its ease of placement. Unlike a bent needle, which displaces tissues along its plane of angulation, a curve needle inserted following its arc will not. This is akin to a curved suture needle, which is driven in a rotating fashion along its arc. There is subsequently less trauma to the tissues.

A second advantage of the curved needle is the ability to use the stylet, which provides more rigidity and stability for improved control during placement and avoids clogging of the needle. Further, bending the needle may weaken it, allowing the possibility

Fig. 1. Straight and curved 3.5-inch, 22-gauge spinal needle. Note the bevel direction (*inset*).

