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,1 one is a single case report. The other article is a report of the use of depot steroids for chronic pancreatitis 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 intraarterial 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 authors, 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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References


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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.

An adverse reaction 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,