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block, certifies whether the needle’s bevel is in the wall of a major blood vessel, passes through a kidney, or lies inside the pleura or in the epidural or subarachnoid space. 3, 5

If the readers of this letter know of the occurrence of a catastrophic sequela from NCPB using CT, it would be helpful in evaluating whether any roentgenographic technique could eliminate a catastrophe from NCPB.

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References


Anesthesiology
1996; 84:1523
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In Reply.—Our patient did not experience paraplegia but aortic dissection, which caused visceral infarct, leading to sepsis and the patient’s demise.

Brown and Moore1 reported two cases of pneumothorax in 136 patients and no permanent neurologic or other complications. They state that the expected incidence of neurologic complications should be less than 1% but provide no reference to indicate how that was determined.

Lieberman and Waldman2 did not report paraplegia as a complication in 124 patients. They referenced the complications of retroperitoneal hematomas (0.1–0.5%) for the transaortic technique specifically and paraplegia (1%) for celiac blocks in general. Although they cite a reference for the approximately 1% stated incidence of paraplegia, that reference does not indicate exactly how this figure was derived, but it appears that it was obtained by combining two case reports of paraplegia to approximately 400 patients they summarized from reported series in the literature. In addition to being an illegitimate means for determining the incidence of an event, none of the 400 patients from the summarized cases were reported to have paraplegia as an adverse event.

Eisenberg et al.3 quote a 1% incidence of neurologic complications, defined as lower extremity weakness, paresthesia, epidural anesthesia, and lumbar puncture. Eight of 268 patients experienced one (or more) of these complications. It is therefore difficult to know the incidence for any particular complication, and paraplegia specifically was not listed.

While a Medline search revealed no complications from celiac neurolysis when computed tomography (CT) was used, this cannot be interpreted that there are none. It can mean only that none have been reported. For example, Brown and Moore1 provide “hearsay” reports in their discussion of seven patients who experienced paraplegia and one who required nephrectomy after celiac plexus block. I also have heard of isolated severe complications (e.g., bilateral renal pelvis scarring and ureteral stricture, massive retroperitoneal hemorrhage leading to death) associated with celiac neurolysis, but these have yet to be brought to the attention of the medical community via journal publications. One can surmise only that not all adverse events from celiac plexus blocks are being reported, regardless of the method by which they are performed.


(Accepted for publication March 6, 1996.)

Although use of CT might eliminate the morbidity from celiac neurolysis, the extremely low incidence of paraplegia from celiac block and vascular injury from transaortic lumbar autografting (referenced in our case report5) would require many thousands of patients to be studied to compare different techniques. I would expect that paraplegia specifically would not be lessened using CT, because any major arterial source to the spinal cord arising from the aorta and in the vicinity of the injected agent could be affected and lead to cord ischemia.

I concur with Moore’s request for readers of his letter to report adverse occurrences and emphasize that all adverse events associated with celiac neurolysis, not just those involving CT guidance, should be reported. However, the only truly accurate determination of complication rates associated with celiac plexus blocks would be through a mandatory central registry of all procedures.

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(Accepted for publication March 6, 1996.)

Anesthesiology. 1996; 84:1523

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