to read their papers. Matters are made worse by the simultaneous projection of obviously old or dirty (not pornographic) slides.

Surprisingly, these sins are not committed infrequently by speakers of both national and international repute, their performance sharply contrasting with some equally illustrious but far more entertaining and, therefore, communicative orators whom I have had the privilege and pleasure of hearing. On one occasion, I recall a famous anesthesiologist and researcher projected numerous slides depicting several paragraphs in tiny print, photographed directly from a book, which he then proceeded to read verbatim! Presumably, the speaker impolitely, either considered the audience illiterate or appreciated the illegibility of the information appearing on the slides from the outset.

Speakers at meetings generally should be more considerate of their audiences, many of whom have traveled hundreds of miles and paid substantial fees to be there. Good communication involves simple but well-established principles designed to allow spread of important information in an interesting and entertaining fashion.

These guidelines are well-covered by several books and articles which should be essential reading to all who aspire towards improving their performance and ability to communicate scientific information from a public podium. Two references I have found of particular value (and very entertaining reading) are listed below for the benefit of those interested in making enjoyable contributions to future symposia and congresses.\(^1\)\(^2\)

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**REFERENCES**


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**An Improved Technique for Celiac Plexus Block May Be More Theoretical Than Real**

To the Editor:—The article by Singler was read with interest.\(^1\) Dr. Singler suggests using a more vertical approach for needle placement and placing the tips anterior to the crura of the diaphragm so that neurolytic solution bathes the celiac ganglia and plexus rather than the splanchnic nerves in the retrocrural space. In theory this would seem optimal; however, in practical clinical application the recommendation has several faults.

Location of the celiac neural axis by CT scanning is fraught with diagnostic problems, in particular, differentiating the celiac artery from the superior mesenteric artery on transverse sectioning. A more practical problem

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**FIG. 1.** When the transcrural approach is employed, usually only one needle is placed at L1 because, even if computed tomography is used, a needle inserted on the left side would in most instances of necessity pass through the aorta prior to puncturing the crus of the diaphragm, as can be ascertained from the above reproductions of the CT scans. A. Needle's bevel anterior to crus of diaphragm. B. Spread from needle in A of 50 ml of radiopaque material (25 ml of absolute alcohol, 18 ml of 0.75% bupivacaine, and 7 ml of meglumine iohexol) USP 60 (600 mg/ml), osmolality = 1.5 m Osm/ml, that is, Conray. L1 = body of first lumbar vertebra. C = crus of diaphragm. a = aorta. M = massive growth of lung metastasis in left adrenal gland. R = spread of radiopaque solution.
is that many patients with carcinoma of the pancreas are inoperable because the tumor encases the superior mesenteric and celiac arteries, so that the potential "space" is obliterated by tumor. Therefore, attempts to place needles so that the neurolytic agent bathes the celiac neural axis may be technically and physically impossible. Although primary localization of the neurolytic agent in the classical technique is in the retrocrural space and about the splanchnic nerves, some of the agent is noted to escape anteriorly, and so the classical method allows not only for a splanchnic neurolysis but also, as anatomy permits, some bathing at the celiac neural axis.

We are concerned about the description of figure 3 in Singler’s article.1 The needle tips are indicated by two asterisks and are stated to lie anterior to the cura of the diaphragm. Yet these seem to project into the retrocrural space; the appearance is that of a classical celiac block as described by Moore, Bush, and Burnett.2 With CT, actual placement of the needles’ bevels can be shown, and it would seem the appropriate way of confirming their location prior to injecting the neurolytic material. Furthermore, we have placed single needles anterior to (below) the diaphragm at L1, and have not found spread of the neurolytic material to be as described by Singler or as illustrated by figure 3 of his article.1 As would be expected at L1, it spread anterior to the cura only and not around the aorta (see fig. 1).

The last statement of Singler’s article, “... the classic technique has worked well and is still used for surgery and diagnostic blockade prior to neurolysis,” raises a fundamental question about altering this technique for neurolysis. Naturally, no technique should be “inscribed in stone” and unalterable in its application. However, it seems to us that to do a diagnostic block via the classical method in an effort to determine if a block will help the patient, to find that the diagnostic block by the classical method is helpful, and then to alter the technique to that of the transcrural method of needle placement, begs the question of common sense.

Finally, the number of cases Singler offers is small; the failure rate with the transcrural technique (two of six) is certainly not less than that when he uses the classical technique (one of five).

In summary, then, we feel that the article offers an advantage in theory only, failing to provide any practical improvement over an established classical technique for celiac neurolysis.

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In reply:—I am pleased that Dr. Moore admits that "in theory [the transcrural approach] would seem optimal." In practice, we have found it technically feasible to use this approach even in patients in whom metastases markedly displace the aorta and nearby structures. Unfortunately, I cannot agree that with the retrocrural technique, anatomy may permit bathing of the celiac neural axis, especially in patients with distorted anatomy.

I would like to provide the accompanying photographs of needle placement using the transcrural technique. As with Dr. Moore's placement, it is simple to demonstrate the actual position of the needle bevels prior to the injection of alcohol. Figure 1 shows needle position at the T12 level, and the subsequent outlining of the celiac artery by contrast material at that level and one centimeter lower.

Dr. Moore has nicely demonstrated the spread of contrast anterior to the aorta in his figure as well. Encircling of the aorta is not necessary, as the destruction of the ganglia obviates the need for retroaortic splanchnic neurolysis. It should be noted that he might have avoided spread of contrast to the renal pelvis if he had used bilateral needles and a smaller volume. Fifty or more milliliters of neurolytic solution are not necessary with the transcrural approach. Finally, the choice of T12 or L1 for the level of injection is determined solely by the CT-assisted location of the celiac axis. As performed routinely using the retrocrural approach, I direct my needle tips to rest at the T12 level (though transcrural) when the celiac artery cannot be located.

I readily admit to being instructed in the original technique by Dr. Moore, himself. Unfortunately, Dr. Moore apparently feels his technique should be "inscribed in stone," as he ignores in his paper,1 and in the above letter, the primary impetus for my subsequent alteration of his technique: the alarming observation of frequent