Letters to the Editor

Comment on "Computed-Tomography-guided Percutaneous Bilateral Neurolytic Celiac Plexus Block with Alcohol for Upper Abdominal Visceral Cancer Pain"

To the Editor:

We have read the article with great interest by Bing et al (1) titled "Computed-Tomography-guided Percutaneous Bilateral Neurolytic Celiac Plexus Block with Alcohol for Upper Abdominal Visceral Cancer Pain". The authors got the conclusion that CT-guided percutaneous neurolytic celiac plexus block (NCPB) that used a double needle to puncture the anterior and posterior diaphragmatic crura could produce a better analgesic effect for patients with intractable upper abdominal cancer pain. However, we would like to discuss some questions with the authors.

Firstly, in this article, the authors did not give the accurate definition on "intractable visceral cancer pain in the upper abdomen" and did not clearly clarify the data extraction and analysis whether blinding was applied, which might be important to the final results. Secondly, it would be more convincing to bring into patients with pancreatic cancer, for which was recognized as one of the most painful malignancies with 70-80% suffering substantial pain, often unresponsive to typical medical management (2,3). Finally, when patients were enrolled, those with intestinal bowel obstruction should be excluded, as it might increase gut motility and put patients at risk for bowel perforation (2).

We would like to share a case of a 41-year-old man diagnosed with right upper abdominal pain and back pain suffered from pancreatic cancer. CT-guided percutaneous right-side NCPB with alcohol was performed. Firstly, after local infiltration anesthesia, a No. 7 lumbar piercing needle was inserted vertically through the skin, which was kept removing closely to the lateral margin of L1 vertebrae until the needle tip reached the anterior side of the right abdominal aorta (Fig. 1). Secondly, 5 mL of 30% iohexol was injected, and the contrasrt spreaded well in the target lateral abdominal aorta (Fig. 2). Then 5 mL local anesthetics including 4 mL 2% lidocaine and 1 mL 1% ropivacaine were administered. Finally, 5 mL anhydrous ethanol was injected.

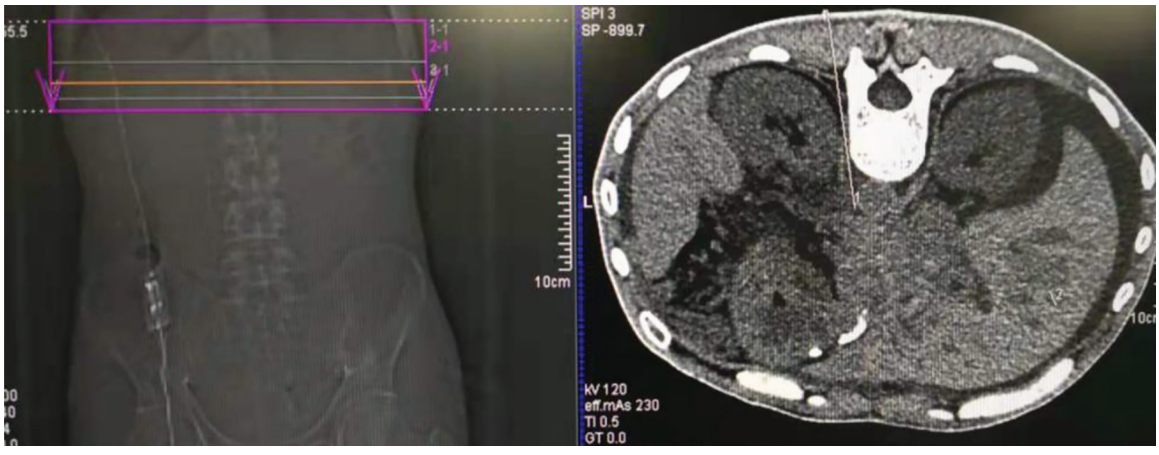

Fig. 1. *The design of the puncture path for posterior transaotic.*

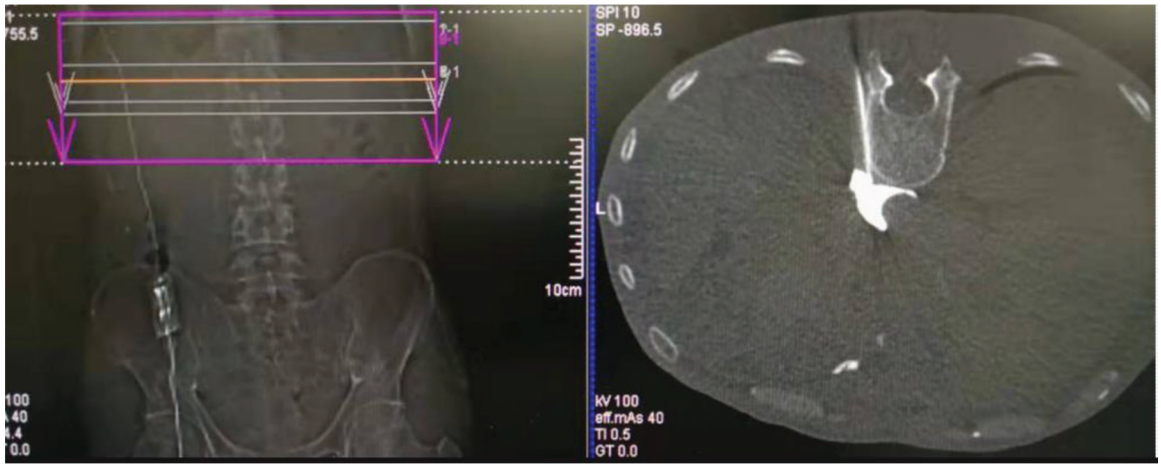

Fig. 2. *The needle tip position and diffusion of contrast material in the antecrural space.*

The patient's right-sided abdominal pain and back pain were significantly relieved, with the visual analog scale (VAS) score decreased to 2 point from the beginning 8-9 point, and no relevant complications were observed during the procedure and the 3 months' follow-up.

CT-guided NCPB with alcohol was safe and effective for the management of upper abdomen visceral cancer pain. However, we should realize that NCPB was an adjunctive tool in the management of cancer-related pain, and its greatest benefit was in reducing opioid dosage and its related side effects rather than completely resolving pain (4,5).

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