
LETTERS TO THE EDITOR

FLUOROSCOPY-GUIDED CAUDAL EPIDURAL INJECTION IN THREE STEPS

To the Editor:

Access to caudal epidural canal is the first step in several chronic pain management procedures including sacral neuroplasty, percutaneous adhesiolysis, and spinal endoscopic adhesiolysis. It can be difficult to identify sacral hiatus by palpation of anatomical landmarks in the adult population. We propose a fluoroscopy-guided approach for caudal epidural injection in three simple steps using the direction-depth-direction principle.

Patient is placed in a prone position and the lumbosacral region is prepped and draped in a sterile fashion. All three steps are performed using both the antero-posterior and -lateral fluoroscopic views.

Step 1: Sacral hiatus is identified as a radiolucent depression underlying the deficient posterior sacral wall in lateral view (Figure 1).

Step 2: Site of needle entry is the center of this radiolucent depression, either in midline or 1–2 cm lateral to midline, as per requirement of the procedure (Figure 1). Needle entry is made in the lateral view at an angle of 45° with respect to the horizontal plane; the dorsal aspect of the ventral plate of the sacrum is contacted. The needle position is also confirmed in antero-posterior view. Loss of resistance is usually felt after penetrating the sacrococcygeal ligament.

Step 3: The needle is slightly withdrawn and the angle of insertion is flattened to 20–30°. The needle is then advanced inside the sacral canal under sequential lateral fluoroscopic views (Figure 1).

The final needle position is confirmed by contrast injection in antero-posterior and -lateral views; contrast spread helps in ruling out intrathecal or intravascular needle placement.

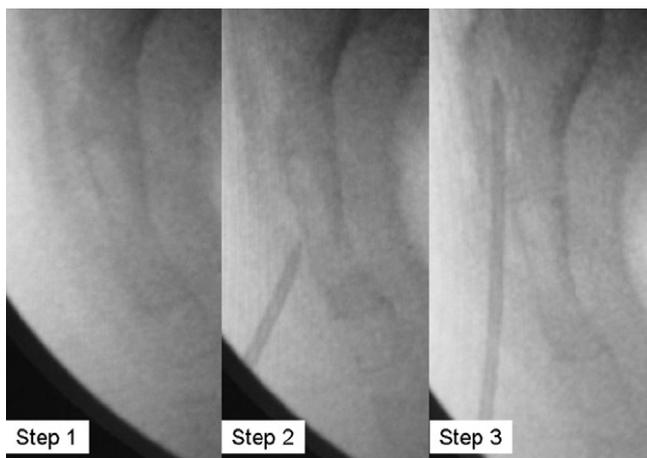


Figure 1. Fluoroscopy-guided caudal epidural injection.

Sujeet Gautam, MD; Virendra Rastogi, MD;
Ankur Jain, MD; Anil Prasad Singh, MD
Department of Anaesthesiology
Institute of Medical Sciences
Banaras Hindu University
Varanasi, India
E-mail: docskskg@gmail.com

THE USE OF PLAYFULNESS IN THE TREATMENT OF CHRONIC PAIN

To the Editor:

It is well documented that from 10 to 55% of the general adult population report chronic pain, while approximately 11% report severe chronic pain.^{1–5} Often, patients suffering from chronic pain find themselves wandering among their primary physicians (eg, orthopedic surgeons), pain experts (eg, anesthesiologists), and psychotherapists in addition to “second opinions” and “alternative therapies,” which are all time and money consuming, turning their ordeal into a career. Consequently a vicious cycle is created as the picture of chronic pain becomes interwoven with depression. Most cross-sectional studies find an association between chronic pain and psychological distress mostly manifested as depression⁶ which on its part exacerbates physical symptoms⁷: Pain breeds demoralization, which leads to shrinkage of activities and satisfactions, in other words—to depression and more pain. Usually, antidepressants are prescribed to deal with the problem presented. The present communication, however, demonstrates by way of a case study a new alternative intervention.

The Patient

The patient was a 57-year-old war veteran. He was badly injured in his leg and spine in a mine explosion and his condition has gradually become worse. He is married with three sons, two of which are married. He has one grandson and interactions with him are the only thing that can make him smile. He was an electronics technician and enjoyed his place of work and contact with co-workers and customers. As he could not stand on his feet for more than a few minutes, he had to go into early retirement. He was treated in various pain clinics, was operated upon to stabilize his vertebra, an intrathecal morphine pump was implanted, which resulted in tormenting side effects, and he was given a variety of pain medication combinations.

Being preoccupied with pain, almost 24 hours a day, made him give up most activities and social contacts and his life was narrowing down, without challenges or achievements.

Discussing resumption of activities he once found satisfying, the patient said that he had lost the urge to do anything. He was sick of having to make decisions on using cold or hot local compresses, which of the medications to take, how often to swallow a pill and whether or not to go to the hospital's emergency room for antipain injections,

Table 1. Cards

Use a distracting application of ice (to an area that is not painful).	Use local application of heat to tissue.	Use local application of ice to tissue.
Take an ampoule of fluid paracetamol.	Go to bed and stay there until some improvement is felt.	Listen to music with ear phones to distract you.
Take a warm shower.	Take a cold shower.	Local application of ointment or spray
Do not talk today about pain at all.	Cocktail: choose any two cards, mix them up and do as instructed.	Take a tablet of OxyContin (a narcotic drug).
Joker:	Have a glass of hard liquor.	Have a glass of wine.
Write memories of your early childhood.	Physical contact with a loving person	Go out of your apartment (coffee, shopping, or friends).
Cook something you like for dinner.	Close your eyes and imagine some lovely landscape. See yourself there.	Diaphragmatic breathing.
Finish a cross-word puzzle.	Find something technical to fix.	Smell and inhale Jasmine flower extract.
Do house chores to the point of exhaustion.	Call a friend or relative for a short conversation.	Watch and edit old albums of family pictures.

which only rarely had a short-term positive effect. He was experiencing a feeling of helplessness as nothing he did really helped in relieving his pain.

In therapy we tried cognitive-behavioral measures, relaxation, self-hypnosis, and a mindful acceptance of his sensations. All of these helped a little but were not enough to bring about a return into nonpain-related activities.

The idea of using chance⁸ for his benefit was presented as an experimental intervention and informed consent was granted by him. The therapist explained that his condition is an expected and normal result of living in constant pain and that it is very difficult to voluntarily go on living as if pain did not exist at all. A more powerful force is needed, in this case, the power of luck and chance. His injury itself was a matter of bad luck and now is the time to invite good luck for help. The patient was willing to go along with the idea.

Using Chance

A blank pack of cards with a distinctive design on their back was used. Usually, stores that cater to kindergartens will carry such cards. It is always possible to “do it yourself” with cardboard or with stickers glued to standard cards. The patient and the therapist sat down to write a first batch of cards, including only assignments that according to his judgment would be easy to carry out. Each card consisted of instruction on measures to use to control pain, or an assignment to carry out. One card was wild, enabling him to decide to do whatever he felt like. It was agreed that he will shuffle and pull out a card every evening, before going to sleep and the card chosen will determine what will take place the next day. During the next few sessions, we added cards and modified some to arrive finally at the deck of 27 cards, shown below (Table 1).

Clinical Impact

The experiment or game lasted for 2 months. The patient carried out the instructions as decided and found the whole idea amusing. He believed that the game took his mind off the pain. He did not report any decrease in the frequency and severity of pain episodes. However, his mood improved and he was less depressed. He started enjoying “little things” such as calling friends by phone and meeting some of them for coffee. He started gathering information about his family’s genealogy, and started planning a website dedicated to it. He also screened old family photos and derived much pleasure out of these nostalgic moments.

The experiment was terminated after a “bad luck” turn of events: his wife, who took care of him, became incapacitated and suffered much pain after a disc ruptured. It was the husband who now had to switch roles and take care of her. He started to drive her around and he had to give up his comfortable armchair. He could not go on complaining about his pains and get empathy from her. He had less time for himself and as all clouds have a silver lining, he had less time for pain.

Conclusion

With the well-known limitations of the case study method notwithstanding, a new method of activation of patients suffering from chronic pain is offered. This technique has no negative side effects: the very enumeration of pleasant activities is beneficial, even if patients decline to carry out the assignments dictated by luck.

This approach does not blame the patient for not being active and does not preach in terms of will power, which is only self-defeating. Thus, the patient’s experience of declined motivation for activity is validated. Introducing chance and luck (this time good ones) agrees with the patient’s conception of bad luck regarding his/her disease or injury.

In addition, such a game is antidote to the tragic frame of mind, resulting from chronic pain in the case of patients and prolonged caring for such patients in the case of therapists.

Uri Wernik, PsyD, TCP
Misgav Ladach Hospital
Jerusalem, Israel
E-mail: wernik@inter.net.il

REFERENCES

1. Benjamin S, Morris S, McBeth J, Macfarlane GJ, Silman AJ. The association between chronic widespread pain and mental disorder: a population-based study. *Arthritis Rheum*. 2000;43:561–567.
2. Gureje O, Von Korff M, Simon GE, Gater R. Persistent pain and well being: a World Health Organization Study in Primary Care. *JAMA* 1998;280:147–151.
3. Nickel R, Raspe HH. Chronic pain: epidemiology and health care utilization. *Nervenarzt*. 2001;72:897–906.
4. Ospina M, Harstall C. Prevalence of chronic pain: an overview. Edmonton, Alberta: Heritage Foundation for Medical Research, Health Technology Assessment. Report No 28, 2002.

5. Verhaak PF, Kerssens JJ, Dekker J, Sorbi MJ, Bensing JM. Prevalence of chronic benign pain disorder among adults: A review of the literature. *Pain*. 1998;77:231-239.

6. Wilson KG, Mikail SF, D'Eon JL, Minns JE. Alternative diagnostic criteria for major depressive disorder in patients with chronic pain. *Pain*. 2001;91:227-234.

7. Hotopf M, Mayou R, Wadsworth M, Wessely S. Temporal relationships between physical symptoms and psychiatric disorder. Results from a national birth cohort. *Br J Psychiatry*. 1998;173:255-261.

8. Wernik U. *Chance Action Therapy*. New York: Nova Science Publishers; 2010.