In Reply:
We thank Dr. Tang for his comments on our article and agree that an anteroposterior view of the C1–C2 intraarticular facet injection would have provided valuable information regarding the trajectory of the needle in the medially-lateral plane. As Dr. Tang points out, an anteroposterior view would have confirmed whether needle misplacement occurred, as suggested by the significant extrarticular spread of radiographic contrast visualized on the lateral image. Indeed, there was no anteroposterior image stored during the conduct of this procedure at the outside institution, thus we have no way of verifying the final needle position. Likely, this image would have demonstrated that the needle tip had deviated dangerously too lateral toward the course of the vertebral artery.

We much appreciate the thoughtful response from Drs. Datta and Manchikanti, and we agree with the recommendation to abandon the practice of intraarticular cervical injections, because the risk seems far out of balance from the scant demonstrated benefit from this procedure. The nonvascular complications of cervical injections that Drs. Datta and Manchikanti describe, including penetration into the subarachnoid space, nerve roots, and spinal cord, further reinforce our position regarding the risk–benefit ratio of this procedure. Even when nonparticulate steroids are used to prevent microvascular injury in the event of an inadvertent vertebral injection, nonvascular complications can still lead to devastating neurologic injury.

Drs. Datta and Manchikanti raise several important points regarding the nomenclature that is used to describe neuroanatomic landmarks in cervical injections. We chose the term “C1–C2 intraarticular injection,” as opposed to “lateral atlantoaxial joint injection” based on the documentation used in the procedure note and because both are frequently used in the published literature, but we do agree that the latter term is more common, particularly in recent publications.

Perhaps most important among their comments, Drs. Datta and Manchikanti raise procedural considerations that affect the interpretation of our report and the very safety of performing injection of the lateral atlantoaxial joint. They state, “…It is not clear from the case report if an anterolateral, lateral or posterior approach was employed …” As shown in figure 1 of our report, the needle enters from a posterior approach. The posterior approach is well described and potentially the safest approach to the injection of the lateral atlantoaxial joint. Nonetheless, even if all appropriate safety measures are implemented, the risks of cervical injections of the lateral atlantoaxial joint are so devastating that they seem to outweigh the unproven benefits. Indeed, as Drs. Datta and Manchikanti suggest, “the best course of action may be to abandon the practice.”

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References

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Why No Casopitant-only Arm?
To the Editor:
In regard to the recent article by Singla et al. concerning the neurokinin-1 receptor antagonist casopitant, I have a num-

Sukdeb Datta, M.D.,* Laxmaiah Manchikanti, M.D.,
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