

- pain due to intervertebral disc herniation: A prospective, randomized, double-blind trial. *Pain Med* 2014; 15:548–55
6. Park CH, Lee SH, Kim BI: Comparison of the effectiveness of lumbar transforaminal epidural injection with particulate and nonparticulate corticosteroids in lumbar radiating pain. *Pain Med* 2010; 11:1654–8
 7. El-Yahouchi C, Geske JR, Carter RE, Diehn FE, Wald JT, Murthy NS, Kaufmann TJ, Thielen KR, Morris JM, Amrami KK, Maus TP: The noninferiority of the nonparticulate steroid dexamethasone *vs* the particulate steroids betamethasone and triamcinolone in lumbar transforaminal epidural steroid injections. *Pain Med* 2013; 14:1650–7
 8. Kraemer J, Ludwig J, Bickert U, Owczarek V, Traupe M: Lumbar epidural perineural injection: A new technique. *Eur Spine J* 1997; 6:357–61
 9. Ackerman WE III, Ahmad M: The efficacy of lumbar epidural steroid injections in patients with lumbar disc herniations. *Anesth Analg* 2007; 104:1217–22
 10. Lee JH, An JH, Lee SH: Comparison of the effectiveness of interlaminar and bilateral transforaminal epidural steroid injections in treatment of patients with lumbosacral disc herniation and spinal stenosis. *Clin J Pain* 2009; 25:206–10
 11. Gharibo C, Varlotta G, Rhame E, Bendo JA, Perloff MD: Interlaminar *versus* transforaminal epidural steroids for the treatment of subacute lumbar radicular pain: A randomized, blinded, prospective outcome study. *Pain Physician* 2011; 14:499–511
 12. Rados I, Sakic K, Fingler M, Kapural L: Efficacy of interlaminar *vs.* transforaminal epidural steroid injection for the treatment of chronic unilateral radicular pain: Prospective, randomized study. *Pain Med* 2011; 12:1316–21
 13. McLean JP, Sigler JD, Plataras CT, Garvan CW, Rittenberg JD: The rate of detection of intravascular injection in cervical transforaminal epidural steroid injections with and without digital subtraction angiography. *PM R* 2009; 1:636–42
 14. Lee MH, Yang KS, Kim YH, Jung HD, Lim SJ, Moon DE: Accuracy of live fluoroscopy to detect intravascular injection during lumbar transforaminal epidural injections. *Korean J Pain* 2010; 23:18–23
 15. Hong JH, Huh B, Shin HH: Comparison between digital subtraction angiography and real-time fluoroscopy to detect intravascular injection during lumbar transforaminal epidural injections. *Reg Anesth Pain Med* 2014; 39:329–32
 16. Gill JS, Aner M, Jyotsna N, Keel JC, Simopoulos TT: Contralateral oblique view is superior to lateral view for interlaminar cervical and cervicothoracic epidural access. *Pain Med* 2015; 16:68–80
 17. Landers MH, Dreyfuss P, Bogduk N: On the geometry of fluoroscopy views for cervical interlaminar epidural injections. *Pain Med* 2012; 13:58–65

(Accepted for publication September 1, 2015.)

Developing Perioperative Physicians

To the Editor:

In their call for action, Kain *et al.*¹ advocate for changing the name of the specialty of Anesthesiology to Anesthesiology and Perioperative Medicine. In addition, they propose modifying the structure of training in this field to increase the number of out-of-the-operating room rotations and lengthening the duration of residency training in order to better prepare individuals to provide high-quality

This letter was sent to the author of the referenced article, who declined to reply.

care before and after, as well as during, administration of anesthesia.

However, an additional option already exists in this regard. Medical school graduates can enter programs that offer combined training in internal medicine or pediatrics, as well as anesthesiology, leading to eligibility for certification by the American Board of Internal Medicine or the American Board of Pediatrics, as well as the American Board of Anesthesiology.² This can be accomplished in 5 yr, rather than taking 6 yr, which would be necessary if a residency in internal medicine or pediatrics was completed separately before training in anesthesiology commenced. A limited number of programs currently offer this combined training, but more would undoubtedly develop should the demand exist. Interestingly, the first individual to enter one of these combined programs (in pediatrics and anesthesiology) graduated this June and has begun fellowship training (in pediatric anesthesiology). Several other individuals are currently in various stages of combined training programs around the country.

Training in a primary care specialty addresses several of the competencies proposed for the Perioperative Surgical Home.¹ Combined residency training could help anesthesiologists become more comfortable and skilled in caring for patients, frequently with chronic and complex medical conditions, preoperatively in clinics and postoperatively in recovery areas, hospital wards, and even after discharge, as well as during anesthesia. Graduates of these programs should also be well prepared to serve as leaders of the Perioperative Surgical Home.

Acknowledgments

Salary support was provided by the CHMC Anesthesia Foundation (Boston, Massachusetts).

Competing Interests

The author was a Director of the American Board of Anesthesiology (Raleigh, North Carolina) from 2000 to 2012 and during that time received travel expenses and honoraria. However, the opinions expressed in this letter reflect solely the author's viewpoint and not that of the American Board of Anesthesiology.

Mark A. Rockoff, M.D., Boston Children's Hospital, Boston, Massachusetts. mark.rockoff@childrens.harvard.edu

References

1. Kain ZN, Fitch JC, Kirsch JR, Mets B, Pearl RG: Future of anesthesiology is perioperative medicine: A call for action. *ANESTHESIOLOGY* 2015; 122:1192–5
2. Combined Training in Anesthesiology and Internal Medicine or Pediatrics. Available at: <http://www.theaba.org/training-programs/combined-training/combined-training>. Accessed June 12, 2015

(Accepted for publication September 17, 2015.)