crossover or a quantum defining methodology will always be subject to the same problem of a differential diagnosis of drug sensitivity and temporary or permanent nerve damage.8–10

Despite the diverse nature of algasia of thoracic surgery and the nature of the treatment, it is a consistent observation that there are no significant differences in pain analogue measures at rest 4 h after the end of the main algiasic insult.7 It is irrespective of whether the algasia is given as a premedication [opioid or local anaesthetic (epidural or paravertebral)], perioperatively or after operation rather than any advantage programmed by pre-insult administration of analgesic.

Of the four objectives for pain relief techniques for thoracic surgery, only two are met by paravertebral injection—the humanitarian, and some reversal of the effects of surgery on respiratory and metabolic function. Epidural techniques meet a third, more ill-defined and less easily measured objective, that of active promotion of healing (unnecessary for most thoracic surgery but obligatory for such operations as oesophagectomy). There is no evidence, but wishful, that a fourth objective—preventing transition to a chronic pain syndrome—is achieved by any algasie technique or way of administration.6,7 Attempting to achieve pre-emptive algasia by injecting local anaesthetic into the paravertebral space is a good example of what J.S. Haldane (1860–1936) called an ignis fatuus.11 My intuition is that the same is true for the whole doctrine.

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Editor—I read with great interest and pleasure the letter from Dr Conacher who has extensive experience in the field of thoracic anaesthesia in general, and paravertebral blockade in particular. It is also always nice to read communications that show a great knowledge not only in medicine but also regarding history and literature and I am pleased to be spared the ‘Occam’s razor’ principle this time around.12

As alluded to in the editorial, some scientists and practitioners frown upon the potential concept of pre-emptive algasia and it is evident that Conacher agrees with this line of reasoning, based on arguments clearly laid forward in his letter. I cannot but agree that most attempts outside animal and volunteer studies have failed to take this concept into clinical medicine. However, for a number of reasons put forward in the editorial, I propose the idea that paravertebral nerve blockade may, and I repeat may, make this block different from other regional techniques. Furthermore, my conclusion in the editorial, as in this reply, is that paravertebral blockade deserves more widespread use, whether producing pre-emptive algasia or not, as it has been shown to provide better postoperative algasia than alternative methods. I will leave for the reader to judge whether this conclusion is valid and as near the truth as we can get today, or if I just represent one of those ‘few enthusiasts’.

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Spontaneous intracranial hypotension: a recent indication for epidural blood patch

Editor—We report the efficacy of a single lumbar blood patch, in spontaneous intracranial hypotension (SIH). SIH is characterized by intense headache leading to neurological referral. Diagnosis is mainly clinical, but magnetic resonance imaging (MRI) shows specific features. If the usual therapy fails, treatment with an epidural blood patch can be effective.

Three female patients presented to our hospital with spontaneous, severe headache. The first patient, aged 38, had bilateral frontal headaches for 24 h, with positional features (decrease after 15 min of resting and increase in upright position). Lumbar puncture and MRI showed no
unusual features. Pain was severe and did not respond to usual therapeutics. After discussion with the neurologists, an epidural blood patch was performed 3 days later by the anaesthetist in the operating room. After insertion of a 19 G Tuohy needle (Vygon, Ecouen, France) at the lumbar level, 16 ml of autologous blood were injected. The headache disappeared within an hour, and the patient was able to leave hospital the next day. The second patient, aged 28, described vertigo and photophobia, with major frontal headaches and inability to sit or stand up for 6 days. Lumbar puncture and brain-CT were normal, brain MRI showed a moderate diffuse pachymeningeal enhancement.

An epidural blood patch was performed on the third day, by the anaesthesiologist, and 12 ml of autologous blood were injected. The headache disappeared within a few hours and the patient was discharged from hospital 3 days later. The third patient, aged 42, described occipital headaches over a period of 3 months with postural features, resistant to usual medical treatment, other than corticosteroids. Brain MRI showed pachymeningeal enhancement, bilateral subdural collection, and downward displacement of the cerebellar tonsil. Blood patch was performed a week later. Headaches disappeared within 48 h. The patient left hospital 3 days later.

These three cases occurred within a 2-month period. SIH is becoming better recognized as recent clinical reports in international anaesthetic literature show.\(^1\) SIH occurs mainly in young adult females. The mechanism the most likely involved is a leak of cerebrospinal fluid.\(^2\) Diagnosis is by clinical features similar to those of our three case reports; orthostatic headaches relieved within a few minutes by lying down; bilateral, diffuse in most cases or occipital headaches; other features such as nausea and vomiting, vertigo, hearing disturbances, blurred sight. The most characteristic feature on MRI is the epidural and meningeal enhancement. Radiographic abnormalities can also be more important, including, as in the third case report, bilateral subdural fluid collections and downward displacement of cerebral structures. The lack of imaging features in the first case report is probably because of the very short time delay between the beginning of the headaches and MRI, and the major changes in the third case can be explained by the long delay for diagnosis. Lumbar puncture shows low cerebrospinal fluid pressure, with no specific abnormalities but is not recommended because of the risk of increasing the hypotension.\(^3\)

No evidence base exists, but treatments such as extended bed-rest, hydration, corticotherapy, caffeine and raising abdominal pressure have been described.\(^4\) If these are ineffective, lumbar epidural blood patch, particularly if done early, appears to be effective.

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**Impossible test or reasonable aim**

Editor—I read the editorial\(^1\) on the human right of patients to be pain free with some interest. I am not an acute pain specialist any more than any other jobbing anaesthetist but I felt that there was an element of strident evangelicalism in their article. Whilst the content of the article may be drawing the reader’s attention to the statements of various laudable self-appointed bodies one must assume the authors are sympathetic to the views expressed, for the statements to be included. The takeaway message of the editorial is that pain relief should be a human right and that failure to treat pain is ‘substandard medicine’. To the man on the street therefore, failure to achieve pain relief is evidence of denial of their human rights. Doctors are not permitted to deny patients their human rights.

For effective treatment to be such an absolute, it must first of all be possible. Clearly it is not possible to treat all pain. The clinician dealing with the patients directly, in the environs of the muddy moat beneath the ivory castle, will inevitably be the recipient of patient’s wrath. Such clinicians are clearly incompetent as they have failed to relieve the patient’s pain. The authors are making promises that others may not be able to keep. All any clinician can ever do is treat to the best of their knowledge and experience and any standard higher than this will set an impossible goal. Older readers will remember the dearth of obstetricians in some States of America during the early 1980s as a consequence of the impossibly high standards set by the lawyers. If such sweeping statements alluded to above are not challenged we will all be exposed to similar tests.

Indeed the essence of the argument for making pain relief a ‘human right’ assumes effective treatments for all sources of pain. If there are effective treatments for all forms of pain then the various articles, organizations, colleges and