**Correct nomenclature of superficial cervical plexus blocks**

Editor—We read with interest the anatomical study by Pandit and colleagues looking at the spread of injectate with superficial cervical plexus block in human cadavers.

We feel that the term ‘superficial cervical plexus block’ as used to describe the site of injection in this cadaveric study is misleading as the paper clearly states that in four cadavers the injections of dye were made ‘just below the investing fascia’. This is not a ‘superficial cervical plexus block’. The classical technique of superficial cervical plexus block was described by Murphy, and Scott. Both these texts describe subcutaneous (superficial) injection of local anaesthetic. Not surprisingly, in the only cadaver in which the dye was injected subcutaneously in Pandit’s study, none spread to the deeper tissues of the neck.

The technique as described by Pandit and colleagues might more correctly be termed an ‘intermediate’ cervical plexus block. This could be viewed as a third method of anaesthetizing the nerves of the cervical plexus, in addition to classical superficial and deep cervical plexus blocks.

It is important to emphasize that classical superficial plexus block as described by Murphy and Scott is clinically effective for carotid endarterectomy. The main theoretical drawback of the use of superficial cervical plexus blocks alone is the lack of neuromuscular block of the neck. In practice, this does not seem to be a problem.

We agree with the authors that a randomized controlled trial comparing ‘superficial’ and ‘intermediate’ cervical plexus blocks as the sole method for providing local anaesthesia for carotid endarterectomy is essential. As the majority of complications of cervical plexus block (intravascular injection, intrathecal injection and impaired diaphragmatic function) are associated with the deep block when local anaesthetic is placed around the roots of the cervical plexus, the ‘intermediate’ cervical plexus block could be a real step forward in the management of these difficult patients.

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Editor—We thank Drs Telford and Stoneham for their interest in our paper. Existing literature indicates that there have been various methods described of the proper injection technique in superficial cervical plexus block. Murphy, Scott, Prys-Roberts, and Katz have all described the superficial injection as being simply ‘subcutaneous’. However, Chaikof and colleagues have suggested it should be ‘intradermal’ (i.e. even more superficial). In contrast, Yerzingatsian advised that the injection should properly be made into the body of the sternomastoid muscle, so that the solution is deposited below the investing fascia. It would perhaps take a medical historian to establish the proper chronology of these various suggestions for cervical plexus block to confirm which of them is the original or ‘classical’ method.

The suggestion of Telford and Stoneham regarding nomenclature is therefore most welcome. The subcutaneous injection might indeed be termed ‘superficial’ (or simply ‘subcutaneous’), and the subinvesting fascia injection might be termed ‘intermediate’. As all complications associated with cervical plexus block arise from use of the deep injection, we are pleased that they agree with our suggestion that it is important for the (two safer) subcutaneous and intermediate injections to be compared directly in a randomized study.

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