Thoracic paravertebral nerve block

Editor—We read with interest the study by Vogt and colleagues, and the accompanying editorial, highlighting long lasting analgesia from a single preoperative injection of bupivacaine and epinephrine for patients undergoing thoracoscopic surgery. We agree that pain following video assisted thoracic surgery (VATS) can be severe but we also believe that, in many thoracic units, it is not taken sufficiently seriously.

Following strenuous efforts studying how to avoid the severe pain which follows open thoracic surgery, with the take up in our unit of VATS—a supposedly minimally invasive alternative—we were appalled at the severity of acute pain and the generation of chronic pain, the latter of which, we measured at 38% at 2 months compared with our chronic pain generation rate following open thoracotomy managed with various analgesic modalities of 22.3% altogether and approximately 10% if managed with paravertebral analgesia. Although the overall figure of 38% sounds high, the second biggest published study looking into chronic pain after thoracotomy reported a 44% incidence at a mean of 30.3 months (15–48) after operation. A second study by the same group found a 61% chronic pain rate at 1 yr.

We wish to share with others our experience which we believe has helped patients. We tackled the problem in three ways. Firstly, we provided patients with single shot paravertebral nerve blocks before operation, using similar methods to Vogt and colleagues. Secondly, the advice of the surgical literature to orbit the instruments about the surgical focus was abandoned. VATS can involve the use of up to five instruments followed by chest drains. Up to five intercostal nerves are therefore at risk of trauma and as far as we were confirmed that the instruments and ports can actually be of larger diameter than many of the spaces through which they must be inserted. We invented a rib punch to take out an ellipse of the upper part of the inferior rib. This minimized the trauma needed for insertion, a modification which we hoped would reduce neurovascular trauma and rib fractures (having previously found that rib removal rather than rib distraction reduced chronic pain following thoracotomy).

In VATS, if longer postoperative analgesia than described by Vogt and colleagues is required, the positioning of a percutaneous catheter under direct vision has been described.

Lönnqvist’s editorial and the report in the same issue of coexisting harlequin and Horner syndromes after high thoracic paravertebral anaesthesia suggest there is much yet to be learnt about this fascinating technique. The keys to its full understanding will indeed lie within sympathetic afferents and efferents.

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Coexisting harlequin and Horner syndromes after high thoracic paravertebral block

Editor—I read with interest the article entitled ‘Coexisting harlequin and Horner syndromes after high thoracic paravertebral anaesthesia’. I recently witnessed a very similar presentation of this rarely reported condition when asked to review a patient with a low thoracic epidural block, in the