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Letter to the Editor

Before Recommending Ultrasound-Guided Superficial Cervical Nerve Block for Musculoskeletal Neck Pain, all Non-Invasive Methods should be Attempted

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Letter to the Editor

We read with interest the article by Tanigawa *et al*. on a case series of five patients who underwent ultrasound-guided superficial cervical nerve block (SFCNB) in the emergency department (ED) for musculoskeletal neck pain [1]. In all five patients, neck pain was reduced from VAS 8–10 to VAS 1–5 [1]. The study is noteworthy, but some points require further discussion.

The first point is that oral analgesics and topical lidocaine are not sufficient to diagnose treatment-resistant neck pain [1]. In order to indicate more invasive measures for pain treatment, it would have been useful to also use intravenous analgesics, muscle relaxants, and, if necessary, antidepressants before recommending SFCNB. Were opiates also administered to treat neck pain? The disadvantage of SPCNB is that it is invasive, which is why all non-invasive therapies should be exhausted before SFCNB is recommended.

The second point is that the diagnostic evaluation for musculoskeletal neck pain and radiculopathy was not described in detail [1]. Were all patients subjected to magnetic resonance imaging (MRI) and X-ray examination of the cervical spine? Patient 1 did not undergo imaging of the cervical spine, even though the patient reported a pain intensity of VAS 10 [1]. Patient 5 also did not undergo imaging despite VAS 10 neck pain.

The third point is that no long-term follow-up data were reported [1]. How long did the five patients report pain relief? How many days or weeks after the SPCNB was the telephone interview conducted? In how many patients did the pain recur and with what intensity?

The fourth point is that no blood test results were reported to determine whether any of the five patients had an acute or chronic infectious or immunological disease. We should also know how many patients had rheumatic disease, were HLAb27-positive, had Chiari malformation, osteochondrosis, spondylosis, spondylarthrosis, listhesis, Hirayama disease, or other confounding conditions.

The fifth point is that neither a depression/anxiety scale nor a stress evaluation was performed to assess the extent to which neck pain was attributable to internal or external stress or depression and anxiety.

The sixth point is that the number of patients was too small to draw general conclusions. In addition, the retrospective design of the study allows only limited conclusions to be drawn from the reported data.

Finally, we should know whether patient 5, who was diagnosed with compression of the C5 nerve by MRI of the cervical spine, had or did not suffer from respiratory insufficiency due to weakness of the diaphragm, which is normally innervated by the C3-5 roots [2].

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