

Ultrasound guided erector spinae plane block for bilateral lumbar transverse process fracture: A new or a pushing indication?



Dear Editor,

We have read with great interest a case report written by Ahiskalioglu et al. [1] entitled “Erector spinae plane block for bilateral lumbar transverse process fracture in emergency department: A new indication”. They performed an erector spinae plane (ESP) block at the T10 level for a 60-year-old female patient who presented with a bilateral isolated L2 transverse process fracture. The ESP block was described by Ferero et al. [2]. The ESP block has been used as a postoperative analgesia technique for various indications such as thoracic surgery and mastectomy. Additionally, ESP block was used for rib fractures for patients with trauma [1]. However, in the case report presented by Ahiskalioglu et al., they decided to perform an ESP block for pain management in the seated position. Unfortunately, although they are considered relatively minor injuries, fractures of the transverse processes (TP) of the lumbar vertebrae appear as a consequence of major forces. Patten et al. conducted a study of transverse process fractures in the lumbar vertebrae, and they found that there is a statistically significant association between transverse process fractures and abdominal visceral injuries such as renal, splenic and hepatic injuries. In their study population, the mortality rate was 10% [3]. In another study, the authors determined that transverse process fractures might be a sign of more severe injuries [4].

We would like to enter the debate and address some of our concerns to the authors. 1) What was the cause of the bilateral lumbar transverse process fracture? Was it from a traffic accident or fall? According to the literature, these types of injuries are not common, and it is possible that a TP fracture might present with other injuries. 2) What was the authors rationale for placing the patient in the seated position after a TP fracture? Is it safe to place the patient in the seated position even though the patient could have important concomitant injuries such as liver, renal and spleen injuries? 3) The healing time for a transverse process fracture has been reported to be between a few weeks and 3 months [5]. In addition, acute pain can develop into chronic back pain. We would like to ask the authors whether they think that managing the pain for only 24 h is sufficient to prevent chronic pain? What were the patient's visual analogue scale scores after 24 h? Did the patient need rescue analgesics during the 24 h after ESP block? What type of oral analgesic was administered? Non-steroidal anti-inflammatory drugs or opioids?

In conclusion, despite the successful pain management with ESP block in the present case report, interpretation of the results should be considered in light of the answers to the abovementioned questions.

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Acute presentations of infective endocarditis



Long and Koyfman have highlighted the acute presentation of infective endocarditis (IE) in intravenous drug users [1]. The acute presentation includes a range of pulmonary stigmata which may dominate the clinical picture almost to the exclusion of an index of suspicion for IE. Those stigmata include chest pain, cough, haemoptysis, pulmonary infarction, lung abscess, pleural effusion, and empyema, respectively, all ultimately attributable to septic emboli [2]. Another acute presentation is the one characterised by acute left ventricular failure and severe breathlessness as a result of IE-related acute aortic valve regurgitation. In acute aortic regurgitation, of which IE is a leading cause [3], a sudden excessive volume load is imposed on an unprepared left ventricle that is normal in size. The consequence is a dramatic increase left ventricular diastolic pressure which may approach or even equal aortic diastolic pressure [4]. One of the consequences is a diminution in the intensity of the heart sounds (the so-called “silent precordium”) and a diminution in the intensity of the regurgitant aortic murmur [4], or even a complete absence of that murmur [4, 5]. Alternatively, the early diastolic murmur of aortic regurgitation may be replaced by a short mid-diastolic component of the Austin Flint murmur [4, 6]. Another variation is the phenomenon of the “continuously regurgitating mitral valve” [7]. This is attributable to coexisting systolic and diastolic mitral regurgitation in the presence of severe aortic regurgitation, and its occurrence may be indicated by the presence of a soft systolic murmur of mitral regurgitation in addition to the early diastolic murmur of aortic regurgitation [7]. In the latter example echocardiography showed mitral annulus dilatation, normal mitral valve leaflets and cordae tendinae, and systolic and diastolic mitral regurgitation superimposed on severe aortic regurgitation [7]. The presence of diastolic mitral valve regurgitation is indicative of critical severity requiring urgent valve surgery, as shown by the