



Re: Adding corticosteroids to the pudendal nerve block for pudendal neuralgia: a randomised, double-blind, controlled trial

Sir,

The authors' conclusion and recommendations in Labat et al.¹ are inconsistent with the experience of many practitioners whose patients have symptom relief or cure following pudendal nerve perineural injections (PNPI) with steroids. Multiple factors appear to affect observations.

1 Perineal pain (perineodynia) is not always present in pudendal syndromes. Single organ symptoms may be the only complaint, e.g. persistent genital arousal, bladder pain.

2 Erroneously, the Nantes criteria consider relief of sitting pain after lidocaine infiltration as a diagnostic criterion. This is a crude and limited surrogate for diagnosis. Pudendal syndromes exist without sitting pain. Diagnosis of pudendal neuropathy is clinical by:

- identifying changes in sensation from normal bilaterally;
- using neurophysiological tests (personal experience: warm detection threshold test; pudendal nerve terminal motor latency test);
- painful pinch roll test of labia; and
- Valleix phenomenon.

3 Injections are never 100% effective. Patients with pudendal neuropathy but without pain relief after PNPI will remain undiagnosed and suffer mistreatments.

- Following pudendal blockade, pinprick at the six pudendal nerve branches provides immediate evidence of lidocaine effectiveness (analgesia or hypoalgesia).

- Pinprick sensory changes are specific both for diagnosis and also monitoring PNPI.^{2,3}

4 Placement of the medications into the sacrospinous ligament may account for failures.

- Surgeons typically find the pudendal nerve compressed within the bi-ligamentary space between the sacrotuberous and the sacrospinous ligaments.

- Compression is typically laterally near the ischial spine (occasionally over that bone).

- Might medications be more effective when infiltrated into the bi-ligamentary space rather than within the ligament?

5 A single perineural infiltration is not an appropriate therapeutic intervention.

- Experience after thousands of PNPI indicate that one PNPI almost never provides therapeutic relief.

6 A series of three PNPI at 4-week intervals is highly successful.

- Relief or cure is possible. Other authors have published their experiences.⁴

- Repetitive, sequential PNPI ($n = 3$ at 4-week intervals) gradually reduce symptoms.⁵ Subjectively, patients often note an increase in pain after week three.

- Validated symptom scores, used weekly, demonstrate the effectiveness of such a treatment series.⁴

7 Pain measurements at 3 months after a single perineural injection are meaningless.

- The authors indicate that the perineural steroid effect in carpal tunnel syndrome lasts only about 1 month. Should we expect PNPI to be effective for longer?

- Bupivacaine affects pain and central sensitisation for only several hours, occasionally a few days; rarely longer. Corticosteroids may heal neural inflammation.

8 'Failure' to relieve pain also occurs when additional pelvic neuropathic pain generators are present and not treated: e.g. thoracolumbar junction syndrome or middle cluneal neuropathy.

The authors simply demonstrated:

1 A single steroid block has no measurable effect after 3 months.

2 Eighteen percent of their patients failed pain relief at 15 minutes following infiltration of lidocaine.

3 A more creative approach to PNPI is needed.

Nuances in evaluating and treating neuropathic pelvic pain require uniform methods for diagnosis, treatment and monitoring. The published paper will erroneously discourage successful treatment of pudendal neuropathy using a series of three PNPI, at 4-week intervals, containing steroids. ■

References

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Authors' reply

Sir,

We conducted this study¹ to validate our usual therapeutic approach, consisting of corticosteroid infiltration in patients with pudendal neuralgia (neuropathic pain of the pudendal nerve) due to entrapment syndrome (nerve compression). Unexpectedly, in contrast with our clinical impressions, this protocol (multicentre, randomised, double-blind, controlled study on 201 patients) failed to demonstrate the superiority of the combination of corticosteroid plus local anaesthetic compared with local anaesthetic alone. This lack of superiority was observed for all parameters studied (pain intensity, patient's global impression, quality of life, mood disorder, functional disability) after infiltration at 1, 2 and 3 months.

We would like to thank Drs Antolak and Chung for their comments concerning their usual practice based on their conviction that three repeated corticosteroid infiltrations at 1-month intervals constitute useful treatment.² Unfortunately, there is little evidence in

favour of such an approach, as it appears difficult to propose three repeated corticosteroid injections when only one injection provides no additional benefit over local anaesthetic, as illustrated by our results.

In contrast, the successful results observed by our colleagues Dr Antolak and Dr Chung could be explained by the specific action of local anaesthetics (always in combination with corticosteroids) on sensitisation phenomena or via a mechanical hydrodissection action.

To validate their usual therapeutic approach, Drs Antolak and Chung would need to conduct, as reported in our paper,¹ a multicentre, randomised, double-blind study with a control arm (anaesthetics and corticosteroids versus local anaesthetics alone) in a homogeneous group of patients satisfying the same consensually recognised inclusion criteria for pudendal neuralgia due to entrapment syndrome (Nantes criteria³ referenced in international classifications,⁴ whose sensitivity was confirmed by our study.¹ By using these clinical criteria, 82% of computed tomography-guided anaesthetic blocks with control of diffusion of the infiltrate were immediately and transiently positive.

However, the ethical basis for such a study would be questionable, in the light of our preliminary results, due to the poor rationale, the absence of a rigorous prospective pilot study, and the risks related to the use of corticosteroids (including infections, diabetic decompensation, localised atrophy).

Nevertheless, the results our study do not condemn pudendal nerve infiltrations, which remain justified, but only with local anaesthetics without corticosteroids. These infiltrations can contribute to the diagnosis of pudendal nerve entrapment syndrome and allow better selection of patients eligible for surgery, as it has recently been clearly demonstrated that pudendal nerve decompression surgery is ineffective when pudendal nerve anaesthetic block is negative.⁵ ■

References

- 1 Labat JJ, Riant T, Lassaux A, Rioult B, Rabischong B, Khalfallah M, et al. Adding corticosteroids to the pudendal nerve block for pudendal neuralgia: a randomised, double-blind, controlled trial. *BJOG* 2017;124:251–60.
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Re: Maternal positioning to correct occiput posterior fetal position during the first stage of the labour: a randomised controlled trial

Sir,

I read with interest the article by Guittier et al.,¹ which concluded that there is no significant benefit of the hands-and-knees position to correct the occiput posterior (OP) position of the fetus during the first stage of labour. I agree with the conclusion; however, controlling factors such as pelvic shape and the degree of fetal head descent described by station were omitted from their study. My impression is that an uncorrected OP position seems to be more common among women with an anthropoid pelvis