PAIN CAN BE FUN

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OUTLINE

• CASE PRESENTATION
• ANATOMY/U/S
• TREATMENT
CASE II

• 18 y.o. male who presents to our clinic with 8 year history of abdominal pain
• Seen by multiple subspecialties

• Multiple tests and procedures done at OSH including MRE, MRCP, CT scan, 3 EGDs and 2 colonoscopies with biopsies, a cholecystectomy and exploratory laparoscopy.
• Visceral hypersensitivity syndrome?
TYPICAL INTERCOSTAL NERVE ANATOMY
EPIGASTRIC ULTRASOUND
CASE III

• He is a 19-year-old man who is approximately five weeks s/p abdominal wall cutaneous nerve neurectomy x3 and DSPNI x2 with implantation of nerve into dermal graft on July 25, 2019

• Hunter reports almost complete resolution of his symptoms and has not had any severe episodes of pain since surgery. He says that his level of pain right now is approximately 1 out of 10

• Recent phone call; Still doing well
CASE PRESENTATION

- 20 Y/O FEMALE S/P RIGHT CERVICAL LYMPHNODE BIOPSY
- Drooped shoulder, tingling and numbness right side of head/neck
- Constant severe burning pain trapezius and pectoral region
- PMH/PSH non contributory
- Neurologic: A&Ox3, Right: absent trapezius,
  3/5 in deltoid in anterior, posterior, and lateral deltoid,
  Atrophy in right trapezius
• EMG shows minimal continuity in spinal accessory nerve

• She is s/p Spinal accessory nerve exploration and neurolysis, Harvest of supraclavicular nerve graft, and Repair of spinal accessory nerve with 2 cm graft Completed on 11/15/18

• Superficial cervical plexus nerve blocks X 3 with excellent but limited duration of relief
ANATOMY OF CERVICAL PLEXUS
CASE III

- 44 y/o male presents with right lateral thigh pain and numbness s/p fall
- Bruising resolved but pain and burning have remained constant
- Right THA in 2/2018 but no changes in his right lateral thigh pain
- An injection done by his rheumatologist which provided no relief
- Neuro intact except for decrease pin prick over lateral thigh along with hyperalgesia
- Diagnosis???
LFCN ANATOMY
LFCN
CASE IV

- 57 y/o male with 21 month history of pain following resection of left foot mortons neuroma
- Started with inversion foot injury abd distal fibular fx
- CRPS by Budapest Criteria
- Management history has included NSAIDs, Gabapentin, sympathetic block x2.
- Stump neuroma at 2nd-3rd intermetatarsal space.
- Distal fibula fracture- Xrays ordered to evaluate healing of fracture
• RPNI with plastic surgery
• Did not resolve his pain
• Now what???
Anatomy at L4 and L5 changes requiring a modification of technique

- Trajectory tends to be more contralateral

- Typical skin entry is one level below target
  - L4 and L5 skin entry locations are typically in the same area (lateral to S1 and S2)

- Epidural entry point at L5 is lateral of midline on the contralateral side
  - L4 epidural entry point is midline

- Needle should be directed towards desired target
SHEATH DELIVERY
SHEATH DELIVERY
SCS TRIAL
SCIATIC PNS
CASE IV
Thank you

Questions?