The following details were *not* stated: the type of sphygmomanometer (61 papers), the diastolic end-point (62), the position of the subject (49), and the number of measurements per assessment (70). Virtually no information was given for the remaining data. We could find no obvious difference between reporting in 1969 and 1979, but the number of studies (36) for 1969 was relatively small.

Comment

The important finding of this study is that in two-thirds of the papers relating to blood pressure published in four prestigious general medical journals one or more of the following were not mentioned: type of equipment used, the diastolic end-point chosen, or the number of readings per measurement. Other pertinent information was also not given. The implications are clear. Firstly, in the interests of scientific accuracy and comparability editors and referees must apply to blood pressure measurement reporting the same critical standards given to other measurement methods. Secondly, if the prevailing carefree attitude to blood pressure measurement is to be corrected to enable more accurate diagnosis and treatment of hypertension the incentive and example for a general reappraisal of measurement teaching must come from those who profess a special interest and skill in the subject.

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² Anonymous. Mild hypertension. *Br Med J* 1980;280:1062.

³ Anonymous. The treatment of mild hypertension. *Lancet* 1980;i:1283-4.

⁴ Hypertension Detection and Follow-up Program Cooperative Group. Five year findings of the hypertension detection and follow-up program. 1. Reduction in mortality of persons with high blood pressure, including mild hypertension. *JAMA* 1979;242:2562-71.

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Coeliac plexus block for control of pain in chronic pancreatitis

Disruption of the nerve supply to the pancreas has not been widely used to control pancreatic pain, despite several studies¹ showing that operative splanchnicectomy, with or without coeliac ganglionectomy, results in satisfactory control of pain in most patients. Denervating the pancreas by injecting alcohol into the region of the coeliac ganglion has been useful for pain associated with pancreatic cancer,^{2,3} but long-term studies in chronic pancreatitis have not been reported. We reviewed 16 consecutive patients with chronic pancreatitis treated by coeliac plexus block; the results indicate that satisfactory control of pain may be achieved by this technique.

Patients, methods, and results

Coeliac plexus block was performed in 16 patients (14 men, two women; mean age 49 years) with advanced chronic pancreatitis associated with disabling abdominal pain. Pain had begun two to 25 years (mean six years) before the procedure, and, at the time of nerve block, 12 of the 16 patients required regular injections of narcotic analgesics. Four patients were managed with high doses of simple analgesics and narcotic analgesic supplements. Pancreatitis was attributed to alcohol abuse in 12 patients, of whom seven had calcification on plain abdominal x-ray examination. Three patients had previously had gall stone disease. Advanced chronic pancreatitis had been confirmed at laparotomy in six patients and by retrograde pancreatography in 12. Fourteen patients were alive for review in December 1979. These patients completed a questionnaire and subsequently attended for interview to clarify their answers. A mean of 3.5 years (range nine months to seven years) had elapsed since the coeliac plexus block. The efficacy of coeliac plexus block in the two patients who had died was evaluated from the medical record.

The technique of coeliac plexus block has been described previously.⁴ A recent modification involves injecting radiological contrast material (Hypaque 60%) before using alcohol to ensure that the points of both

needles are positioned correctly (figure) with the point of the needle on the right side being more cephalad than that on the left.⁴

Thirteen of the 16 patients (81%) had experienced a substantial reduction in the severity of pain within two weeks of nerve block. Pain relief had lasted for less than six months, however, in three of these patients. Ten of 16 patients (63%) showed long-term improvement: three are completely free of pain and seven had only mild pain, which is readily controlled by non-narcotic analgesics. Five of the six patients with continuing pain underwent a second coeliac plexus block and two subsequently improved. Two patients with ineffective blocks underwent pancreatic resection and subsequently died. Postural hypotension was common for one to two weeks after coeliac plexus block but thereafter resolved spontaneously. The only long-term complication was persistent nerve root pain in one patient, possibly related to the tracking of alcohol along the needle track to the L1-L2 nerve root.

Lateral x-ray film showing needles positioned across body of L1. The needle on the right (long arrow) is more cephalad than that on the left, and the position of alcohol in the retroperitoneal space (short arrows) has been outlined by a second injection of radiological contrast.

Discussion

The degree of pain control achieved by coeliac plexus block may be similar to that achieved by pancreatic surgery.⁵ Furthermore, the procedure is fairly simple and safe and does not appear to increase the degree of difficulty of subsequent pancreatic resection. Severe pain recurred within six months of nerve block in three patients, but recurrence of severe symptoms at a later stage was not observed. These findings suggest that coeliac plexus block (carefully performed under radiological control) has a place in the management of pain associated with chronic pancreatitis and should be considered before pancreatic surgery.

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