

Response to Letter to the Editor: Percutaneous pulsed radiofrequency ablation of articular nerves of the hip joint in patients with chronic hip pain refractory to conventional analgesics

Editöre Mektuba Cevap: Kronik kalça ağrısı olan hastalarda konvansiyonel analjeziklere dirençli kalça eklemi artiküler sinirlerinin perkütan puls radyofrekans ablasyonu

Sandeep Diwan¹, Anju Gupta²

¹Department of Anaesthesiology and Critical Care, Sancheti Hospital, Pune, India

²Department of Anesthesia, Pain Medicine and Critical Care, AIIMS, New Delhi, India

We express our sincere gratitude to the authors for their interest in our article titled “Percutaneous Pulsed Radiofrequency Ablation of Articular Nerves of the Hip Joint in Patients with Chronic Hip Pain Refractory to Conventional Analgesics”^[1] and value the opportunity to elucidate several significant points mentioned in their correspondence.

Initially, we concur that the nomenclature related to radiofrequency (RF) techniques has been historically inconsistent in the literature. Pulsed radiofrequency (PRF) is mechanistically distinct from traditional continuous radiofrequency neurotomy, especially concerning tissue temperature and the lack of pronounced thermocoagulative lesions. Nonetheless, the phrase “pulsed radiofrequency ablation” has been inconsistently employed in pain literature since its inception in clinical practice until the recent times. It is generally referred to as radiofrequency therapies aimed at neural targets, despite the lack of true destructive neurolysis.^[2,3] We recognize that the language may lack semantic precision, and that “pulsed radiofrequency treatment” or “pulsed radiofrequency neuromodulation” would offer a more technically accurate description. We commend the authors for emphasizing this distinction. Importantly, despite increasing use of pulsed radiofrequency interventions (PRF, pulsed

RF, PRF lesioning, PRF ablation, RF denervation, RF neurotomy, RF lesioning, RF neuromodulation), at least, we are unaware of an universally accepted Delphi-based consensus nomenclature defining the terminology of PRF versus ablative RF techniques.

All patients in the study had chronic refractory hip pain and were undergoing multimodal pharmacological care prior to referral for interventional treatment about the use of pregabalin. Pregabalin was not given as a study-specific intervention; instead, it was a component of the baseline conservative analgesic regimen indicated before contemplating operative therapy (often prescribed by the surgeons). Given that all patients were administered a similar baseline analgesic regimen, we do not consider this to have created a differential impact on treatment outcomes. Importantly, our study reflects a real-world clinical practice model in a high-volume orthopedic referral center, where interventional pain procedures are commonly integrated with ongoing pharmacological therapy rather than preceded by complete withdrawal of existing analgesics. The sudden cessation of chronic pain medications exclusively for procedure assessment may not always be practical or ethically justifiable in patients experiencing extreme refractory pain.^[3] We recognize that the justification for referencing these

Corresponding author: Anju Gupta.

E-mail: dranjugupta2009@rediffmail.com

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medications may have been articulated more clearly in the manuscript to eliminate uncertainty.

We express our gratitude to the writers for meticulously evaluating the procedural statistics. The observation about Figure 1b is duly noted. The fluoroscopic image seems more medial than the textual description indicates, possibly due to projection orientation and fluoroscopic angulation during image acquisition, rather than an intentional mismatch in target position. The procedural strategy was primarily based on the notion that nociceptive innervation of the anterior hip capsule is distributed over the capsular brim in both medial and lateral regions rather than confined to a single fluoroscopic spot.^[4] The targeting approach therefore intentionally sought coverage across the anterior capsular articular territory, including femoral and obturator articular contributions, which may variably project on two-dimensional fluoroscopic imaging.^[5,6] Consequently, isolated interpretation of static fluoroscopic needle position may oversimplify the procedural rationale without considering the underlying three-dimensional capsular anatomy.^[7,8] We concur that enhanced radiological clarity and labelling would have augmented reproducibility for readers endeavouring to execute the process. We value this insightful remark and concur that enhanced figure representation is consistently preferable in image-guided intervention literature.

Finally, we are encouraged that the correspondence has stimulated detailed technical discussion regarding hip articular branch interventions. Such exchanges are valuable because they remind all of us that, in pain medicine, terminology, anatomy, and fluoroscopic interpretation often generate nearly as much debate as the intervention itself.

We thank the authors once again for their thoughtful comments and for their contribution to advancing discussion in this evolving field.

Author Contributions

All authors contributed equally to this article.

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