Reply to the Letter to the Editor

Reply to the Letter to the Editor: Infrapatellar Saphenous Neuralgia After TKA Can Be Improved With Ultrasound-guided Local Treatments

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To the Editor,

We would like to thank Drs. Hung and Chang for their interest in our recent article on treating chronic medial knee pain after TKA. We feel that injury to the infrapatellar nerve is not uncommon and must be considered in the differential diagnosis of chronic pain post-TKA.

In our *Results* section, we noted that 13 of the 16 patients (81%) showed improved pain scores of at least 50% after our treatment [1]. Ten of the patients reported pain scores of 0 or 1 out of 10 and were very satisfied with their results. All of the patients underwent traditional physical therapy with no improvement of their pain. Many of the patients had a trial of gabapentin with minimal improvement of their pain. One of the three patients that had no response to therapy underwent lumbar decompression for radicular pain into his knee. The other two patients had multiple chronic pain issues patient including diffuse lateral and medial knee pain.

I agree with Dr. Chang that the PainDETECT score and the DN4 questionnaire [4] may be helpful in

evaluating and monitoring these patients with suspected infrapatellar neuralgia. Our current practice is to do a followup phone call at 24 hours and 7 days postinjection. If their pain returns, we do a repeat injection 2 to 4 weeks after the initial injection.

The infrapatellar nerve can be readily identified with ultrasound as it branches from the saphenous nerve. However, the nerve can be difficult to visualize in the medial aspect of the knee [2, 3]. We currently identify and mark the maximum point of tenderness along the course of the infrapatellar nerve and scan for the nerve between the fascial planes. Nerve stimulation is used to confirm close approximation of the needle to the nerve (patients report a pulsatile sensory paresthesia). After injection, the nerve can usually be clearly seen when surrounded by local anesthetic. One patient had severe pain for more than a year. This particular patient reported pain scores of eight out of 10 at rest and 10 out of 10 with movement, which could be isolated along the course of the infrapatellar at the midpoint of the patella. The patient was a self-referral to our center after

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her primary surgeon was unable to treat her ongoing pain. The patient underwent one injection with complete resolution of her pain for more than 18 months. We believe the patient may have had some fascial adhesions of the nerve and the hydrodissection released the nerve.

We are encouraged by our limited retrospective study that neuralgia of infrapatellar nerve injury may be effectively treated with an ultrasound-guided block. We have now treated

more than 40 patients with infrapatellar neuralgia with similar results.

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