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Headache after Lumbar Puncture

To the Editor: I read the recent article "Chronic Headaches in Family Practice" by Robert Smith.[1] I have had 5 years experience in family practice before beginning my anesthesia training, which gives me a somewhat unique point of view. While the article was very informative, I would like to point out some incorrect information that appeared on p. 594 concerning postlumbar puncture headache.

While it is correct that lower cerebral spinal fluid (CSF) pressure is believed to be the cause of the headache and that the hallmark of a postdural puncture headache is relief when the patient lies flat, the information about a blood patch is incorrect.

If a postdural puncture headache lasts 24 to 48 hours and fails to respond to intravenous hydration and caffeine, then the treatment of choice is an epidural blood patch. Ten to 20 mL of the patient's whole blood is aseptically injected into the *epidural* space at a vertebral interspace as close as possible to the previous dural puncture. The blood is injected slowly with the end point of headache relief or 20 mL. This is effective 90 percent of the time.[2]

The blood patch works by forming a clot on the *outer* surface of the dura and blocking the leak of CSF. This action prevents the lowered CSF pressure and hence the headache resolves. No further subarachnoid injections are needed, as was stated in the article.

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The preceding letter was referred to the author of the article in question, who responds as follows:

To the Editor: Thanks to Dr. Orman for his informative letter. His expanded description of the postlumbar headache treatment method makes a useful addition to my recent article. He rightly corrects my account of the mechanism of the blood patch by pointing out that the injection is made into the epidural, not into the subarachnoid space. It is good to be corrected on a matter such as this by a family physician.

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Single-Payer System

To the Editor: Dr. Howard Brody's editorial on the American Academy of Family Physicians' plan for addressing current problems with health care in the United States[1] is on the mark in most respects, but the author's assessment of the benefits to be derived from switching to a single-payer system appear unduly optimistic.

As the editorial states, the much-touted figure of $50 billion in annual savings would require not only the adoption of a single-payer system but also a program of global budgets for health care institutions. In effect, the government would negotiate (while holding the purse strings) how much it would pay each hospital or other health care facility for a year's services. Each institution would be forced to survive, if possible, on its allotment. This outcome is not inevitably bad and it might be unavoidable,[2] but it would be stressful for administrators, professionals, staffs, and probably also for patients, and it could have a considerable adverse impact on quality of care.

The much-quoted Woolhandler and Himmelstein article[3] has been largely discredited by subsequent analysis in the same journal's "Letters"[4] and elsewhere.[5] The article reflected a diligent effort to compare costs under the present US and Canadian systems but foundered on discrepancies in what was measured and on multiple, sometimes unquantifiable differences in the two nations' health delivery systems. The latter include the level of entrepreneurial activity by physicians, the impact of a "medical-industrial complex" on decision making, the expectations of patients, and the proportion of physicians doing primary care.

As noted by Ginzberg[2] and others, recent and projected increases in medical spending in the United States are of such magnitude that no viable scheme in our present political climate is likely to bring about the required cost savings. Wennberg[6] asserts that the necessary economies could be derived from making our system more rational (in his context, by persuading Boston physicians to practice as economically as those in New Haven), but changes in medical practices and standards of this magnitude could require decades, even with strong persuasion from third-party payers.

To underscore the enormity of the crisis, consider that an annual saving of $50 billion, even if it could be achieved, would be swallowed up within a year by the relentless increase in health care costs, which have continued to expand at two to three times the inflation rate despite diverse and increasingly powerful attempts to contain them. Dr. Brody is correct in asserting that the AAFP proposal falls short of what is needed, but any plan Draconian enough to address the problem adequately would, in the present climate of US public and professional opinion, be politically nonviable.

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