

INTRA-ARTICULAR (ZYGAPOPHYSIAL) JOINT INJECTIONS

These safety practices have been developed to highlight the important elements in the safe performance of interventional pain procedures. Adherence to these practices will help decrease the risk of preventable complications. For additional information about the indications and technical aspects that yield improved treatment outcomes, refer to the *SIS Practice Guidelines for Spinal Diagnostic and Treatment Procedures*.

PERSONNEL

- Only physicians trained in the performance and interpretation of facet joint injections should perform this procedure.
- Appropriately trained personnel are needed for the operation of the fluoroscopy unit and to assist the physician.

CONTRAINDICATIONS

ABSOLUTE

- An active systemic infection or a localized infection within the procedural field
- Uncooperative patient
- Allergy to medication(s) that cannot safely be mitigated by pre-treatment
- Pregnancy

RELATIVE

- Concurrent treatment with anticoagulants constitutes a relative contraindication for injections involving intra-articular facet joint injections. Although recent guidelines categorized lumbar and thoracic facet interventions as low risk, with cervical designated as moderate risk, this applies to facet medial branch blocks and radiofrequency neurotomy specifically. The guidelines do not cover bleeding risk associated with anticoagulated patients undergoing facet joint injections.

SEDATION

- Sedation is not intrinsically necessary for facet joint injections, but if employed in unique circumstances (e.g. movement disorder, cases of extreme anxiety, previous vasovagal response), the patient should remain able to communicate pain or other adverse sensations or events.
- Use of sedation may alter diagnostic conclusions.
- The decision to use sedation should be made on a case-by-case basis.
- If the physician performing the procedure decides to administer and supervise the sedation, they should be trained and qualified to do so. In these situations, a separate healthcare provider is required to assist with the administration of the medications and monitoring of the patient.
- Resuscitation drugs, monitoring equipment, and oxygen must be available if sedation is utilized.



SAFE, ASEPTIC PRACTICES

- Strict aseptic technique should be followed at all times as they pertain to the facilities, materials, patient preparation, physician preparation, personnel, and injectate/syringe preparation. Examples include, but are not limited to:
 - Skin overlying the target region should be prepared for an aseptic procedure, preferably using chlorhexidine in alcohol. The area should then be draped to create a sterile field.
 - A face mask and sterile gloves must be worn during the procedure.
 - Sterile single-use syringes and needles are required, and single-dose vials should be utilized when available. Centers for Disease Control and Prevention (CDC) guidelines for safe injection practices must be followed.
 - Acquisition, storage, and utilization of medications should be in accordance with relevant governmental guidelines such as those of the CDC in the United States.

IMAGING

- Use of image guidance is critical to ensuring appropriate needle placement. Image guidance reduces the risk of complications, allowing the physician to avoid vulnerable vascular or neural structures, as well as the pleural cavity in the case of thoracic facet joint injections before any agent is administered. Live imaging during contrast injection ensures that the injected agent is delivered to the target and nowhere else.
- The imaging technique should follow the ALARA protocols (as low as reasonably achievable) to minimize x-ray exposure for both the patient and the healthcare team.
- Fluoroscopic guidance has been used in the primary literature investigating the safety and efficacy of facet joint injections, while the same rigor of investigation has not occurred for alternative image-guidance (e.g. CT or US). Fluoroscopy is currently the recommended image-guidance modality for facet joint injections.
- Before injecting any agent, two views should be obtained to show correct needle placement and to exclude penetration into the vertebral canal. Those views should be an AP view plus an oblique or lateral view from which the location of the needle tip can be accurately determined.
- Obtain images documenting final needle position and satisfactory contrast spread.

INJECTIONS

- The safest choice of approach or technique to use should ultimately be made with a thorough understanding of the anatomy and orientation of the joints as outlined in the *SIS Practice Guidelines for Spinal Diagnostic and Treatment Procedures*, balancing potential risks and benefits with each technique for each patient.
- Final needle position within the intra-articular facet joint should be confirmed by injection of a small amount of contrast.
- Physicians must be mindful of the small volume contained within the facet joint (particularly in the cervical joints).



POST-PROCEDURE MONITORING/FOLLOW-UP

- Patients should be monitored for an appropriate time following the injection depending upon the nature of the intervention and the agents utilized.
- Provide detailed oral and written discharge instructions to patients that outline:
 - activity restrictions for the immediate post-injection period (e.g. not to operate a motor vehicle or machinery for the remainder of the day),
 - potential expected side effects that may occur immediately post-injection and in the first few days following the procedure (e.g. pain at injection site, increased blood glucose level if steroid is administered),
 - symptoms that merit immediate medical attention,
 - when to resume usual medications and anticoagulants if discontinued for the procedure, and
 - special instructions for diabetic patients if corticosteroids were utilized.
- Ensure patients have a follow-up plan.

SOURCES

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DISCLAIMER

While these Safety Practices are intended to identify elements critical to the safe performance of interventional spine procedures, they are not intended to be inclusive of all proper methods relevant to the safe performance of spine procedures, or exclusive of other methods of care reasonably utilized to obtain the same results. Nothing contained in these documents is intended to be used as a substitute for the care and knowledge of the individual clinician. They are guidelines based on evidence-informed expert consensus. SIS makes no representation and assumes no responsibility for the accuracy of the information contained or available through this website, and such information is subject to change without notice. The clinician's independent medical judgment, given the individual patient's clinical circumstances and preferences, should always determine patient care and treatment. Practitioners are advised to consider management options in the context of their own training and background and institutional capabilities when selecting recommended treatment options. SIS is not responsible nor does it assume any legal liability or responsibility for the accuracy, completeness, clinical efficacy, or value of any such information or any apparatus, product, or process described or referenced through this website or the information contained therein.



SPINE INTERVENTION SOCIETY

SAFETY PRACTICES FOR INTERVENTIONAL PAIN PROCEDURES

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- MODULE 2.1 FACET INTERVENTIONS: MEDIAL BRANCH BLOCKS
- MODULE 2.2 FACET INTERVENTIONS: INTRA-ARTICULAR (ZYGAPOPHYSIAL) JOINT INJECTIONS
- MODULE 2.3 FACET INTERVENTIONS: MEDIAL BRANCH RADIOFREQUENCY NEUROTOMY
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- MODULE 4.2 NEUROSTIMULATION: PERIPHERAL NERVE STIMULATION
- MODULE 5 PROVOCATION DISCOGRAPHY
- MODULE 6 VERTEBRAL AUGMENTATION

THE INTERVENTIONAL SPECIALISTS' FREE RESOURCE TO HELP DECREASE THE RISK OF PREVENTABLE COMPLICATIONS

For additional information about the indications and technical aspects that yield improved treatment outcomes, refer to the *SIS Practice Guidelines for Spinal Diagnostic and Treatment Procedures*.

