

epidural blood patch (EBP).² Considering some patients may not be candidates to EPB for medical or religious reasons, we have favored a self-applied SGB technique³ obtaining satisfactory results.

Nevertheless, EBP is not always avoided. A recent study by Jespersen *et al*,⁴ comparing SGB with sham block (saline) showed no statistically significant difference in pain intensity 30 min after the block. We think that the best approach (like in every pain management) must be multimodal. Relying on one single method to treat pain is not the best option. We have perceived positive effects of SGB for postdural puncture headache concordant with other studies and still practice it particularly in COVID-19 times, thus avoiding blood contact and sometimes an operating room.

Currently, our multimodal approach includes the addition of intravenous neostigmine and atropine as described in 2018.⁵ These drugs depolarize cervical sympathetic ganglia, block sphenopalatine ganglion (again), and regulate vascular tone and cerebrospinal fluid secretion. SGB combined with 20 µg/kg neostigmine and 10 µg/kg atropine in 20 mL of 0.9% saline given over 5 min intravenously every 8 hours remains a practical and non-invasive option.

Thankfully, nowadays, we have few patients requiring this multimodal management, but excellent results are coming. We encouraged anesthesiologists to avoid EBP in times of pandemic and opt for a multimodal approach that includes non-invasive SGB and evidence-based pharmacological treatment.

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Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

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To cite Rocha-Romero A, Roychoudhury P, Carvajal G. *Reg Anesth Pain Med* 2021;**46**:838.

Received 3 October 2020

Accepted 6 October 2020

Published Online First 27 October 2020

Reg Anesth Pain Med 2021;**46**:838.

doi:10.1136/rapm-2020-102175

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Facing postdural puncture headache in COVID-19 times

To the Editor

We read with great interest the recent report by Levin and Cohen¹ describing safe, simple and inexpensive methods to administer the sphenopalatine ganglion block (SGB). We are aware of their previous work showing a faster relief by SGB and fewer complications than