High cervical cordotomy has been found to be an effective procedure in relieving patients of intractable pain. Originally applied to patients with high body pain, its technical simplicity has led us to use it also for relief of pain in the pelvis and lower extremities.

The operation may be carried out under general anesthesia. Because of occasional variation in the topical arrangement of the fibers, however, we prefer to do the procedure under local anesthesia so that we may test the patient’s sensation and evaluate the efficacy of section at the time of incision of the cord.

The patient is placed in the prone position, with care to maintain the head at a level slightly below horizontal (Fig. 1). This prevents inrush of air after opening the subarachnoid space, which may produce considerable headache and distract the patient’s attention when sensory loss is tested. After infiltration of the skin with procaine or xylocaine, the needle is directed paraspinally to block the second and third cervical nerves as they leave the spinal canal.

A midline incision is made extending from 2 cm below the inion to the rostral margin of the third cervical spine. In performing unilateral cordotomy, muscles are then sepa-

Fig. 1. The patient is placed in a prone position, with the head slightly lower than the body, to avoid inrush of air into the cranial subarachnoid space.