NEWSLETTER

PAKISTAN SOCIETY OF ANAESTHESIOLOGISTS
KARACHI - CHAPTER

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Pakistan Society of Anaesthesiologists Karachi 2009-2010

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REGIONAL ANAESTHESIA FOR GYNAECOLOGIC PROCEDURES

Gynaecologic surgery includes a wide variety of procedures, many of which are performed in the ambulatory setting. Procedures range from the relatively simple dilatation and curettage (D&C) to the more complex staging laparotomy for advanced gynaecologic cancer[1]. Regional anaesthesia is suitable for most gynaecologic surgery, particularly transvaginal and perineal procedures. Advantages of regional over general anaesthesia for gynaecologic surgery include better postoperative analgesia, less postoperative nausea vomiting (PONV), earlier return of bowel function and reduced thrombo-embolic events[1]

The specific technique and choice of local anaesthetic (LA) depends on the magnitude and duration of the operation. The surgical site dictates the level of anaesthesia required. When used for intraabdominal surgery, a level of at least T8 is advised.

Single Dose Techniques

Singe dose techniques are indicated for procedures that are either short or of a predictable duration. Spinal anaesthesia has the advantage of providing a fast, dense and reliable block with a low dose of local anaesthetic. Hyperbaric preparations (0.5 % bupivacaine or 5 % lignocaine) permit greater control of block height, less hemodynamic stability and earlier recovery which is useful in day care setting. A variety of adjuvants (opioids, clonidine) can be added to enhance the quality of spinal block[2].

Caudal anaesthesia is not often used in modern gynaecologic surgery because it is lengthy to administer, requires relatively high dose of local anaesthetic and has an onset of 10 to 20 min.

Paracervical or intracervical blocks coupled with monitored intravenous sedation is appropriate for certain procedures such as D & C, D & E and hymenotomy. Care should be taken regarding the appropriate selection of patients.

Continuous Techniques

Continuous epidural anaesthesia in combination with general anaesthesia is mostly used in major gynaecological procedures (abdominal hysterectomy, debulking cancer surgery) for pain relief[3]. It is seldom used as a sole technique because it require 15 20 min to establish the sufficient block, higher concentrations of LA required which can result in hemodynamic instability and difficult for patients to maintain posture during surgery for longer periods of time especially with steep trendlenburg position.

Combined spinal and epidural Anaesthesia (CSE) offers advantages over the epidural or single injection spinal anaesthesia alone. It involves the use of a minimal dose of spinal anaesthetic for a shorter duration but allows flexibility of epidural reinforcement if necessary[3].

In conclusion, many factors which discourage the use of regional anaesthesia for gynaecologic surgery can be overcome with appropriate techniques and adjuvant agents.

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www.nysoraworld.com

10th Annual Neuro meeting
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Siena, Italy.
http://www.annualneuromeeting.it

SOAP 42nd Annual Meeting
May 12-15, 2010
San Antonio, Texas, United States.
http://www.soap.org/meetings.htm

ANAESTHESIA FOR CAESARIAN SECTION

Introduction
Caesarian birth has become the most common hospital based operative procedure and accounts for more than 25% of all live births in U.S.A.

The choice of anaesthesia for caesarian section depends on the indications for the surgery, the degree of urgency, maternal status, the patient's preferences and the skills of the anaesthetist.

Types of Anaesthesia for Caesarian Section

1. Regional Anaesthesia
2. General Anaesthesia

Regional Anaesthesia
Regional anaesthetic techniques are now becoming the most preferred methods for anaesthetising patients for caesarian births and constitute approximately 80% in frequency in the U.S.A.

Regional anaesthetic techniques have several advantages over general anaesthesia which include

1. A decreased risk of failed intubation and pulmonary aspiration of gastric contents by mother.
2. Avoidance of exposure to neonate of depressant drugs
3. Ability of mother to remain awake and enjoy the birth experience
4. Lesser incidence of blood loss

Although epidural, spinal, continuous spinal and combined spinal epidural techniques have all been advocated, most caesarian sections are done with single shot spinal anaesthesia.

Spinal Anaesthesia
It has a very rapid onset and provides a dense neural block. There is little or no risk of local anaesthetic toxicity and minimal transfer of drug to fetus. Disadvantages include the limited duration (1.5 - 2 hrs), higher incidences of hypotension, incomplete or patchy blocks and post dural puncture headache.

Hyperbaric bupivacaine is the most commonly used agent for spinal aneasthesia. Increasing the dose increases block height, therefore, doses above 15 mg are not recommended.

Epidural Anaesthesia
This technique is usually employed in women with an indwelling epidural catheter for labor who require caesarian section. In high risk parturients epidural can be placed early so that they will be available for emergency caesarian sections.

In comparision to spinal anaesthesia very large doses of local anaesthetic are used to achieve adequate levels for caesarian section and,therefore, more chances of local anesthetic toxicity.

Intra operative and post oprative pain management is improved if a shorter acting opiod is added to the local agent.

Combined Spinal Epidural Technique
The advantage of this technique is that it provides rapid onset of dense surgical anaesthesia while allowing the ability to prolong the block with an epidural catheter.

Smaller doses of local spinal anaesthetics are required which reduce the incidence of high spinal block and hypotension.

Continuous Spinal Anaesthesia
This technique requires the insertion of a 32 gauge catheter through a 26 gauge spinal needle.It has been abandoned after withdrawl of these catheters by the FDA. However, it can still be used in high risk parturients in whom smaller doses can be given through catheter in incremental fashion.

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CME REPORT 2008 PSA KARACHI CURRENT CONCEPTS

Department of Anaesthesiology, Critical Care and Pain Management, Liaquat National Hospital Karachi organized a CME on **"Update on Anaesthesia"**, in collaboration with Pakistan Society of Anesthesiologist on 9th November 2008 at Main Auditorium Convention Center Liaquat National Hospital. The theme of this CME was "Current Concepts". The programme begun with brief introduction of event by Dr. Ghulam Murtaza Consultant

Anaesthetist Liaquat National Hospital, followed by Tilawat. The following lectures were delivered:-

- Management of Difficult Airway in a Child by
- Dr. Prof. Fauzia Anis Khan
  AKUH
- Optional fluid management in the peri operative period
  Dr. Sadqa Aftab
  Consultant, CHK
- Management of peri operative Arrhythmias
  Dr. S. M. Nadeem
  Consultant Anaesthetist,
  Liaquat National Hospital
- Peri operative management of invasive cardiovascular monitoring
  Dr. Hashmi, Consultant
  Patel Hospital

The speakers enlightened all with the current updates and provided opportunity to learn the recent management trends. Session was informative and interactive.

It was a well attended session by both consultants and postgraduate trainees from various institutions of Karachi and other cities.

The session concluded with vote of thanks by Dr. Nighat Abbas Consultant/Head of the department Liaquat National Hospital.

Dr. Nighat Abbas
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General Anaesthesia

Although regional anaesthesia has greatly reduced the use of general anaesthesia it is still necessary in certain situations such as

1. Anticipated excessive maternal haemorrhage
2. Overt coagulopathy
3. Life threatening fetal compromise
4. Refusal of regional anaesthesia by patient

General anaesthesia also has the advantages of speed of induction, control of the airways and better haemodynamics.

Potential problems with this technique include failed intubation,pulmonary aspiration of gastric contents, neonatal depression and awareness of mother.

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PSA PRESS RELEASE ON WRONG DRUG INJECTION

A Press Conference was held on 15th July, 2009 at PMA House Karachi to raise awareness regards unfortunate"Wrong Drug Injection". All the leading News Papers and Media Personals were there to cover this event .The Press Release Issued by Pakistan Society of Anaesthesiologists (PSA) 16th July, 2009 Karachi is as under:

According to a news report in a section of the press that a young boy, 20 years of age, student of an engineering university is fighting for his life in a local private hospital after having been injected a wrong injection by a staff nurse few weeks ago. This is not a first incidence of its kind; many cases have been reported in different hospitals, public and private. Some are reported but unfortunately most of the cases are not reported. The main culprit behind all these cases was an injection called "transamin" which is being used to control bleeding. What actually happens is that Doctors prescribe injection transamin in their broken hand writing, but a semiliterate person at the medical store gives injection "tracrium" and again a semiliterate staff nurse in the ward without cross checking injects this injection to the patients, and the ultimate result is the death. Injection tracrium is a drug used by the Anesthetist to paralyze all the muscles of the body during the surgery. There is absolutely no other use of this drug any where else and no other person except a trained and qualified anesthetist is eligible to use this drug. In the above mentioned case the story is the same but the drug used in place of transamin was "acuron", which is exactly the same drug like tracrium with a different brand name. There are so many other cases in which the drugs prepared by different pharmaceutical companies are so similar to each other in there packing and the color of their ampoules that it is difficult for a person with an ordinary qualification to recognize and appreciate the difference. The Pakistan Society of Anesthesiologist is greatly concerned with the situation and feels that some appropriate measures should be taken to stop this unnecessary loss of life. PSA suggests the following

1. No staff nurse, in any case, be allowed to inject any injection to the patient.
2. It should be the responsibility (moral and legal) of the doctor on the duty to give all the injectable drug to the patient in his/ her supervision.
3. All the pharmaceutical companies who are in business of making these kinds of "dangerous" drugs (dangerous in the sense that these are specifics drugs and of no ordinarily use) should be labeled in such a way that every user should immediately know that this is a drug specifically used in the operation theatre, a sign like "For O T Use Only" with some color coding. It will definitely minimize the risk of wrong injections.
4. These specific drugs should never be available in the ward,
5. Doctors should be careful in prescribing injection transamin, but if at all it is necessary to prescribed this injection than there should be a clear cut instructions "to be injected by the doctor on the duty"

Dr. Safia Zafar Siddiqui
Gen. Secretary
PSA Karachi

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