

Welcome to ESRA Updates

May 2020 | Issue 02



Editorial (P. 2)

[> Read More](#)



Neuraxial Anesthesia and Peripheral Nerve Blocks (P. 3)

[> Read More](#)



Chronic Pain Practice (P. 8)

[> Read More](#)



16th ESRA Winter Week (P. 14)

[> Read More](#)



3rd European Day: more than 1700 participants (P. 15)

[> Read More](#)



ESRA Innsbruck Pain and Regional Anaesthesia cadaver (P. 18)

[> Read More](#)



PROSPECT's Corner (P. 22)

[> Read More](#)



Interview with Patrick Narchi (P. 24)

[> Read More](#)



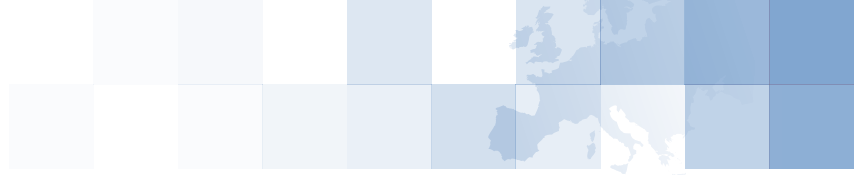
Interview with Fellow Harry Thompson (P. 27)

[> Read More](#)



EDPM (P. 31)

[> Read More](#)



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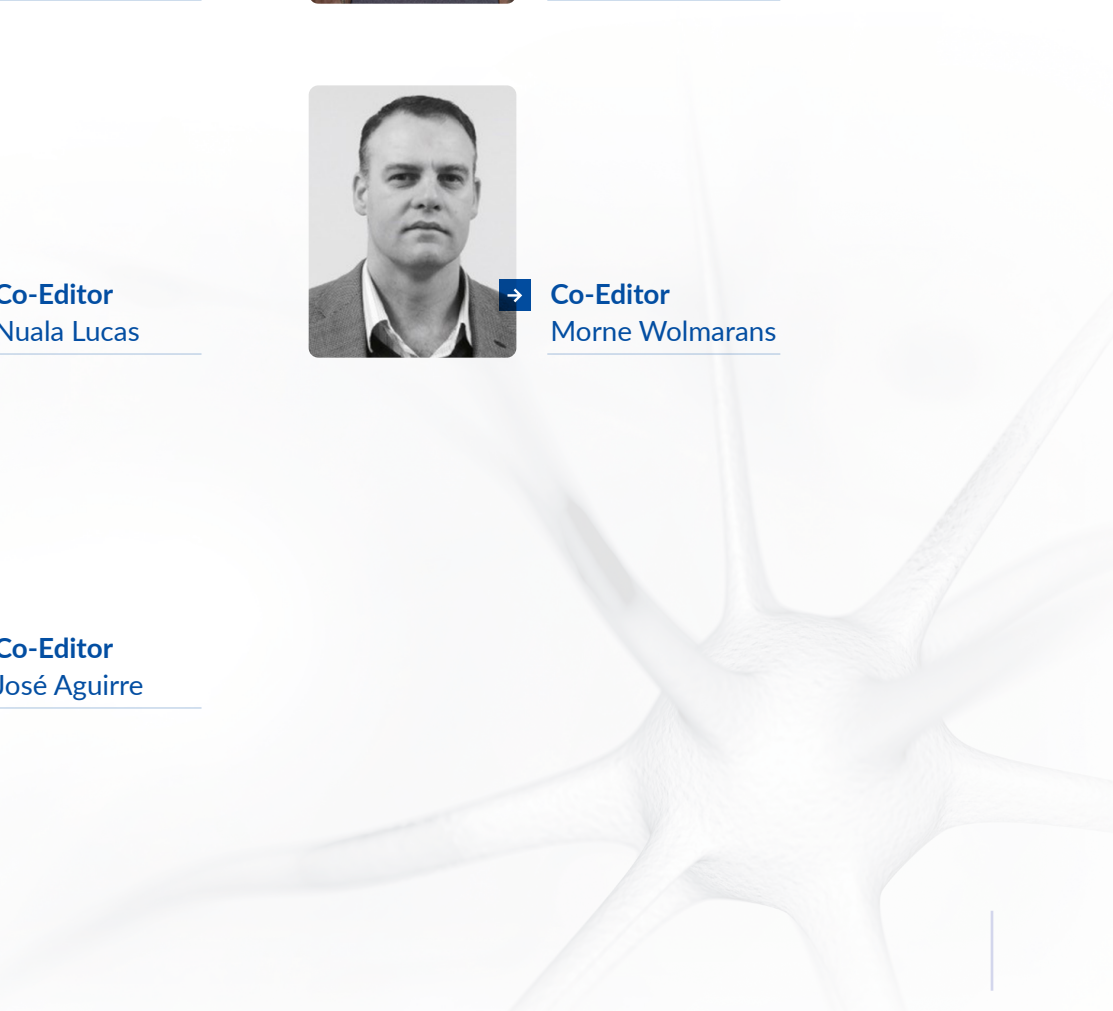
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Editorial

We hope to find you all well and in good health.

COVID-19 has totally transformed the pattern of our lives, personally and professionally. The need for social-distancing and isolation has underlined the importance of the networks and bonds that we previously took for granted. In many ways, this separation has actually bridged some of the distances between us; we are more unified in rising to meet the challenges presented by COVID-19. Our speciality is in the centre of the storm. Within the community of ESRA, we have seen at first hand the unique demands of the COVID-19 era. The provision of high-quality regional anaesthesia has never been more important.

Recognising the need for guidance in these difficult and unstable times, ESRA and ASRA have joined together and developed recommendations related to regional anaesthesia and pain medicine to assist you with the management of COVID-19 patients.

ESRA has developed a section dedicated to COVID-19 on ESRA Academy. Here you can find updated documentation, reviews of regional anaesthetic techniques, and other useful information. ESRA members have free access to the USabcd e-learning platform as well. This contains fantastic resources, including advice about pulmonary ultrasound, to assist with caring for COVID-19 patients.

At its core anaesthesiology is a science based on constant monitoring and safety for our patients. COVID-19 has reminded us of the crucial importance of ensuring safety for healthcare workers. It is always worth reiterating that we must look after ourselves with the correct use of personal protection equipment.

But there is, and will always be, life away from COVID-19. If you want to 'get away' for a while, you can fly away and take a journey through ESRA Updates and its mountains and slopes. In this edition there is plenty of exciting reading; the adventures of the European day, Winter week and Innsbruck Pain and Regional Anaesthesia Cadaver Workshop organised before the pandemic; Patrick Narchi describes his professional journey as a regional anaesthesiologist and Harry Thompson tells us about life as a regional anaesthesiology fellow.

There is a new normal in our working lives, but COVID-19 will not always dominate. You may want to prepare to take the EDPM, and we provide some tips and tricks for your preparation for the exam! PROSPECT has published its latest recommendation on oncological breast surgery, essential reading for anaesthesiologists who work in this area.

Tough times don't last, tough people do. Never has this been more true as the anaesthesiology community and broader medical profession meet the challenges of COVID-19. We look forward to seeing you all in person before too long.

In the meantime, we wish our members, their families and all our colleagues the very best.

ESRA Major Officers

Neuraxial Anesthesia and Peripheral Nerve Blocks



Vishal Uppal, MBBS, FRCA, MSc (Clinical Trials)



Sree Kolli, MD



Rakesh V. Sondekoppam, MD

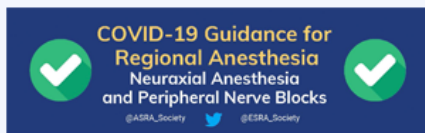


Hari K.P. Kalagara, MD, FCARCSI, EDRA



Clara A. Lobo, MD

A Joint Statement by the American Society of Regional Anesthesia and Pain Medicine (ASRA) and European Society of Regional Anesthesia and Pain Therapy (ESRA).



[Click here](#) to read our Guidance on COVID-19 for Regional Anesthesia

Note: The following represent current recommendations based on the best available evidence and expert opinion. These are not guidelines. Recommendations may change as the situation continues to evolve. This document was last updated on March 31, 2020.

- > The document assumes that anesthesia care will be needed only on urgent and emergent surgeries or surgeries that are lifesaving (such as cancer surgeries).
- > All elective surgeries should be postponed to reduce the risk of exposure to COVID-19 and to conserve the capacity of the healthcare system, personnel, and resources for a possible increase in demand.

Background

General anesthesia (GA) with airway intervention leads to aerosol generation, which exposes the health care team to risk of transmission of COVID-19 both during intubation and extubation.¹ The odds of transmission of acute respiratory infection during tracheal intubation to a health care professional is known to be 6.6 times compared to those who are not exposed to tracheal intubation.²

The tracheal intubation for a COVID-19 positive patient is ideally performed in a negative pressure room, which may not be available in all places or situations.³

Avoiding GA is also beneficial for patients as regional anesthesia lowers the risk of postoperative complications, and this becomes more important in the context of ongoing respiratory infection.^{4,5} Regional anesthesia should be preferred for providing anesthesia care wherever possible.

Careful consideration should be given to allow the surgery to be performed entirely under regional anesthesia. *An unplanned need for intraoperative conversion to GA is least desirable. If the duration or complexity of surgery means a high probability of conversion to GA, it is better to start with GA.* This requires good communication between the anesthesia and surgical teams.



Preparation and Planning

- > *The first step in the planning of anesthesia for a patient during the COVID-19 pandemic is to ascertain if the patient is COVID-19 negative, COVID-19 positive, or suspected to be positive (PUI- patient under investigation).*⁶

COVID-19 negative patient

- > If the patient is not COVID-19 positive, not suspected to be positive, or not PUI, then regional anesthesia can be provided following usual local institutional guidelines as before the pandemic.
- > *Once the community spread of COVID-19 is significant, all cases may be presumed to be COVID-19 positive.*

COVID-19 Positive or PUI

- > Both neuraxial anesthesia and peripheral nerve blocks are not considered aerosol-generating procedures; therefore, dealing with a COVID-19 positive or PUI requires regular contact and droplet precautions.⁷ *This includes the use of a surgical mask, eye protection, surgical gown, and double glove for personnel involved in performing these procedures.*
- > The use of N95 (FFP3) masks or similar powered air-purifying respirator (PAPR) is not generally needed but may be considered for prolonged close contact with a positive patient in a closed setting.⁸ Given the shortage of respirator masks, the N95 or FFP3 mask should be conserved for aerosol-generating procedures such as tracheal intubation and extubation.^{9; 10}
- > Importantly, all patients should wear a surgical mask to restrict the droplet spread.¹¹
- > Avoid high-flow oxygen using nasal prongs as this can lead to the dispersion of droplets and possible aerosol generation.¹²
- > If the patient needs supplemental oxygen, an oxygen mask should be preferred over the nasal prongs.
- > The flow of supplemental oxygen should be kept to the minimum needed to maintain oxygen saturation, to reduce the risk of aerosolization.
- > The surgical mask can be used over the oxygen mask to limit the dispersion of droplets.
- > The regional anesthesia procedure for a COVID-19 or PUI patient should be performed in the operating room or labor room for an obstetric patient. The use of common areas, such as a block room or a holding area, should be avoided as it may lead to cross-infection.
- > The most experienced person should perform the regional anesthesia technique. The donning of personal protective equipment should occur before entering the room.

Equipment

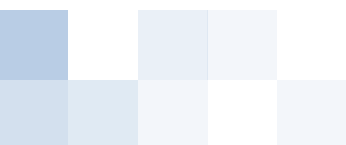
- > The required equipment and drugs should be prepared and packed in a plastic bag before the procedure.
- > The ultrasound equipment, including an ultrasound transducer, should be protected from contamination using plastic covers. Bringing a cart or trolley with drugs and equipment to the procedure room should be discouraged.
- > The number of personnel present during the performance of the procedure should be minimized, but help should be readily available.



Spinal Anesthesia and Epidural Analgesia

- > Although there is limited evidence, the use of spinal anesthesia is not contraindicated for a COVID-19 positive or PUI.¹³ The routine indications and contraindications for spinal anesthesia apply when dealing with PUI or COVID-19 positive patients.
- > Caution should be exercised when attempting to reduce the duration of the spinal anesthetic by using short-acting spinal anesthetics or reducing the dose of the spinal anesthetic agent as conversion to GA is least desirable.
- > It is advisable to rule out thrombocytopenia as there is preliminary evidence to suggest that it might occur in patients with severe COVID-19 disease.¹⁴
- > The routine asepsis technique should be followed. A laboratory study indicated that COVID-19 virus particles are viable for longer on plastic than cardboard; the change in practice to sterile paper drapes instead of plastic ones may be considered only if available.¹⁵
- > As the virus has been isolated from cerebrospinal fluid (CSF) in patients who suffered from COVID-19 encephalitis, an attempt should be made to reduce contamination by not allowing the CSF to drip freely after lumbar puncture.¹⁶
- > Currently, no dose adjustment of spinal anesthesia or adjuvant opioids is recommended. However, a change to the epidural infusion regimen may be needed to reduce the need for additional top-up doses that require frequent patient contact.
- > Although we have not observed the susceptibility of COVID-19 positive parturient to hypotension following neuraxial technique, a single, small case series suggests the possibility of excessive intraoperative hypotension when prophylactic vasopressors were not used.¹⁷
- > The anesthesia provider should be prepared with the strategies to deal with hypotension following neuraxial procedures.¹⁸
- > If resources enable, care of COVID-19 positive patients should be provided in a negative pressure room.
- > All the charting and electronic recordings should be accessible to do from outside the room if possible.
- > The disposal of consumables used after the procedure should be carefully done to avoid any risk of transmission.

Management of PDPH

- > There is currently no guidance available for the management of post-dural puncture headache (PDPH) in a patient with COVID-19. Conservative measures should be tried first.
 - > Nasal sphenopalatine ganglion block is likely an aerosol-generating procedure as it involves an injection/insertion into the nasal cavity and increases the risk of COVID-19 transmission to health care professionals. Therefore, it should be avoided in COVID-19 positive patients.
 - > There is obvious concern about injecting viremic blood in epidural space if an epidural blood patch is needed, especially during an active illness. It might be preferable to postpone the blood patch until recovery from the infection. However, if the headache is severe and debilitating, the epidural blood patch could be performed, balancing the risk of neurological complications associated with severe untreated headache against the theoretical risk of injecting viremic blood in the epidural space.
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Peripheral Nerve Block

- > The preparation and asepsis should be similar to that followed for the neuraxial procedure. If possible, attempts should be made to choose the block that is least likely to interfere with respiratory function. In other words, axillary or infraclavicular brachial plexus block should be chosen over supraclavicular brachial plexus block, and superior trunk block or other alternatives are preferred over interscalene block.
- > The pre-procedural sedation dose may need to be reduced to avoid any respiratory compromise requiring supplemental oxygen.
- > A safe dose of local anesthetics (LA) should be calculated and used; the blocks should be performed with ultrasound guidance to reduce the risk of local anesthetic systemic toxicity (LAST).¹⁹
- > The benefit of perineural adjuvants must be balanced against the risks of possible immunosuppression (dexamethasone), sedation, bradycardia and hypotension (clonidine and dexmedetomidine), drug errors, and drug contamination.
- > The decision to insert and maintain perineural catheters needs to be made on a case-by-case basis. While continuous catheter techniques can be labor and resource intensive and may require frequent patient contact, the opioid-sparing effect of regional anesthesia can be beneficial to a patient with respiratory morbidity. Hence, the use of inpatient perineural catheters should be evaluated based on patient needs and available resources. Ambulatory perineural catheters may still be utilized with clear patient instructions.
- > Similarly, the risk-benefit of analgesic peripheral nerve blocks and fascial plane blocks also should be evaluated on a case-by-case basis. If the block is performed under GA and requires repositioning of the patient, there is a risk of tracheal tube disconnection or dislodgement. Therefore, it may be advisable to choose a block that does not require patient repositioning (e.g. TAP blocks) over those that require repositioning (eg, erector spinae block), if appropriate.
- > In general, any additional analgesic block procedures should be avoided if adequate analgesia can be achieved using alternate regimens such as systemic analgesia.

Monitoring and Conduct

- > Both neuraxial anesthesia and peripheral nerve block should be thoroughly tested for block success before proceeding with surgery to minimize the need for conversion to GA. In the case of peripheral nerve block, extra onset time should be allowed to reduce the risk of conversion. If intraoperative conversion to GA is required, the emergency airway procedure should be followed, as described in the literature.²⁰
- > Excessive or deep sedation should be avoided to reduce the need for any airway manipulation or interventions.
- > The patient should wear a surgical mask at all times throughout the procedure.

End of Case

- > The patient should be monitored in the operating room until safe and before transfer to a COVID-19-designated area of the hospital, as per local guidelines.
- > It has been shown that the risk of transmission is highest during the doffing of personal protective equipment (PPE). Extra time should be allowed for donning and doffing.
- > The presence of an observer during the donning and doffing procedure is highly recommended. Simulation sessions should be conducted for training staff in donning and doffing of PPE.⁶
- > Any reusable equipment utilized during the procedure should be disinfected as per institutional guidelines.

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Chronic Pain Practice



Harsha Shanthanna, MBBS, MD, MSc, FRCPC;
Steven P. Cohen, MD



Sam Eldabe, MBBS, FRCA



Natalie Strand, MD



Anuj Bhatia, MBBS, MD, FRCA, FRCPC



Clara A. Lobo, MD



Samer Narouze, MD, PhD

A Joint Statement by American Society of Regional Anesthesia and Pain Medicine (ASRA) and European Society of Regional Anesthesia and Pain Therapy (ESRA)



[Click here](#) to read our Guidance on COVID-19 for Chronic Pain Patients

Note: As the situation continues to rapidly evolve, the following represents current guidance based on the best available evidence and expert opinion. This document was last updated on March 27, 2020.

Background

Novel coronavirus-2019 (initially referred as 2019-nCoV) is a human b-coronavirus that has been renamed as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). From the observation of the initial 1099 patients with confirmed COVID-19 infection, 6.1% patients had severe infection (ICU admission, invasive mechanical ventilated, or death). Common symptoms were fever (43.8% on admission and 88.7% during hospitalization) and cough (67.8%). The median incubation period was 4 days (interquartile range, 2 to 7).¹ Because of the highly infectious nature of the disease, the risk of transmission is high. The mortality rate seems to be higher than previous estimates noted from China; mortality rates would be 5.6% (95% CI 5.4–5.8) for China and 15.2% (95% CI 12.5–17.9) outside of China.² These numbers are likely to change over time as COVID-19 testing increases, especially in asymptomatic patients, leading to more positive cases and a drop in fatality rates. Mortality and morbidity can be caused by acute respiratory distress syndrome, arrhythmia, shock, acute kidney injury, acute cardiac injury, liver dysfunction, and secondary infection.^{1,3}

General Considerations in Chronic Pain Patients

- > Susceptibility of chronic pain patients could be higher as many are elderly with multiple comorbidities and potential immune suppression.^{4,5}
- > Significant immune changes occur in a patient with COVID-19 disease.^{3,6} Chronic pain exerts complex effects on the immune system, including immunosuppression in some individuals.⁷
- > Chronic opioid therapy may cause immune suppression in some patients, and individual opioids differ in their potential.^{8,9}
- > Use of steroids in interventional pain procedures may induce immune suppression. Intraarticular corticosteroid injections have been associated with higher influenza risk.¹⁰



General Recommendations

Any elective, in-person patient visits or meetings have to be suspended.

- > Whenever possible, telemedicine should be considered. Although most jurisdictions have relaxed the administrative restrictions around the use of telemedicine, practitioners must ensure that the interface used satisfies the rules and regulations of their place of practice.

No elective pain procedures, except specific semi-urgent procedures, should be performed.

- > Across most parts of the world, all elective surgeries and procedures have been postponed or cancelled. Reasons include decreasing the exposure of patients and healthcare providers and conserving resources already strained by diminished production capacity and travel and shipping restrictions during this public health crisis.¹¹
- > Categorizing pain procedures as elective, urgent, and emergent is – in many cases – subjective. For example, not performing or postponing a procedure may lead to significant morbidity and other adverse sequelae. In chronic pain patients, withholding pain management services could lead to inability to work, anxiety and depression, and reliance on opioid therapy. The American College of Surgeons provides some direction in this regard, noting that both medical and logistical contexts must be considered on a case-by-case basis.¹²
- > Although most chronic pain interventions fall under the elective category, there are some situations that fall into the urgent or emergent categories. Below are examples of such procedures along with recommendations on management.

Scenarios of “urgent” pain patient procedures during the COVID-19 pandemic

Intrathecal pump (ITP) refills and malfunction

- > ITP refills necessitate in-person meeting and evaluation. See below for information regarding performing procedures and precautions.
- > Use telemedicine as much as possible to resolve or sort out issues.
- > End-of-life ITP battery requires urgent replacement to avoid withdrawal symptoms.
- > Avoid insertion of any new ITPs, except for highly selected cancer pain cases where the benefit is considered to outweigh the risk.
- > Following careful discussion with the patient, consider the risk/benefit of using higher drug concentrations for the period of the pandemic in order to reduce ITP refill visits.

Neurostimulator infection and malfunction

- > If an implant infection is suspected, an in-person evaluation may be necessary. Depending on whether the infection is superficial or deep, device explant may be warranted and should be performed as soon as possible.¹³
- > Use telemedicine as much as possible to resolve and sort out issues.
- > Avoid any new trials or implants.



Scenarios of “semi-urgent” pain patient procedures during the COVID-19 pandemic

Any elective, in-person patient visits or meetings have to be suspended.

- > Whenever possible, telemedicine should be considered. Although most jurisdictions have relaxed the administrative restrictions around the use of telemedicine, practitioners must ensure that the interface used satisfies the rules and regulations of their place of practice.

No elective pain procedures, except specific semi-urgent procedures, should be performed.

- > Across most parts of the world, all elective surgeries and procedures have been postponed or cancelled. Reasons include decreasing the exposure of patients and healthcare providers and conserving resources already strained by diminished production capacity and travel and shipping restrictions during this public health crisis.¹¹
- > Categorizing pain procedures as elective, urgent, and emergent is – in many cases – subjective. For example, not performing or postponing a procedure may lead to significant morbidity and other adverse sequelae. In chronic pain patients, withholding pain management services could lead to inability to work, anxiety and depression, and reliance on opioid therapy. The American College of Surgeons provides some direction in this regard, noting that both medical and logistical contexts must be considered on a case-by-case basis.¹²
- > Although most chronic pain interventions fall under the elective category, there are some situations that fall into the urgent or emergent categories. Below are examples of such procedures along with recommendations on management.

Opioids and COVID-19

Significant immune changes occur in patients with COVID-19 disease.^{3,6} Most patients have normal or decreased white blood cell counts and lymphocytopenia. The potential for thrombocytopenia exists in severe cases.^{1,14} Opioids are recognized as causing immune suppression, and individual opioids differ in their potential.^{8,9} Although some have observed buprenorphine to have less effect on animals’ immune systems,^{9,15} it is not clear if this is consistently observed in humans.⁸ Some suggest that there may be beneficial immune effects by opioids as well.¹⁶ Patients with COVID-19 who are receiving opioids can be more susceptible to respiratory depression, and the absorption of fentanyl during transdermal administration (fentanyl patch) may increase with fever.

- > ***We do not recommend any changes to ongoing opioid treatment regimens in the absence of documented changes in pain and/or function.***
- > ***We do recommend careful monitoring of patients on transdermal opioids, as the rate of absorption with high fever can be unpredictable.***



Opioid prescriptions and telemedicine

Changes to opioid prescriptions should be made only after careful evaluation of ongoing treatment, which ideally includes an in-person history and physical exam. However, considering the nature of the current COVID-19 health emergency, it is appropriate to make changes and/or continue prescriptions using telemedicine.

- > Use telemedicine to evaluate and continue opioid prescriptions.
- > Ensure adherence to the subscribed needs of telemedicine required by your state or country of practice.
- > Ensure all patients receive their appropriate prescription of opioids to avoid withdrawal.
- > Provide naloxone education and prescription for high-risk patients

In the United States, the Secretary of Health and Human Services declared a public health emergency on January 31, 2020, under 42 U.S.C. 247d (section 319 of the Public Health Service Act), as set forth in 21 U.S.C. 802(54)(D).¹⁷ Based on this edict, any telemedicine allowance under section 802(54)(D) applies to all schedule II-V controlled substances in all areas of the United States. Accordingly, the Drug Enforcement Administration (DEA) notes that DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided the following conditions are met:¹⁸

- > The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice
- > The telemedicine communication is conducted using an audio-visual, real-time, two-way, interactive communication system
- > The practitioner is acting in accordance with applicable Federal and State laws.

Use of Anti-Inflammatories for Chronic Pain

Although a single report suggested that the use of non-steroidal anti-inflammatory drugs may increase the severity of COVID-19 disease¹⁹, most health authorities note that the evidence is not definitive.²⁰⁻²² However, anti-inflammatory drugs may mask early symptoms of the disease such as fever and myalgias.

- > ***We recommend that all patients who have been prescribed or use non-steroidal anti-inflammatory drugs on a regular basis to continue using them.***
- > ***We recommend educating patients who are taking anti-inflammatory drugs to promptly report mild fever or new myalgia.***

Steroids in Chronic Pain and COVID-19

- > Chronic pain patients may be on oral steroids or may have received a recent steroid intervention.
- > Patients on steroids have a potential for secondary adrenal insufficiency and altered immune response.²³
- > It is appropriate to discuss any new therapy that may influence the course of COVID-19 disease with the treating infectious disease physician, as using steroids for all patients as a treatment adjunct in COVID-19 is not recommended.⁶
- > Injections of corticosteroids into joints was shown to be associated with a higher risk of influenza.¹⁰
- > The duration of immune suppression could be less with the use of dexamethasone and betamethasone.²⁴
- > Consider evaluating the risks and benefits of steroid injections, and use a decreased dose, especially in high-risk patient populations. There are many procedures in which steroids are routinely used, wherein the evidence does not support the practice.²⁵

Procedural Precautions and Conduct of Procedure

Any patient who has been determined to need a procedure or an in-person meeting must be screened for the possibility of COVID-19. A history of travel to high-risk areas or countries and the presence of symptoms increase the likelihood of infection, but patients who self-quarantine may become infected and asymptomatic transmission is also possible. Once the community spread of COVID-19 becomes significant, all cases may be presumed to be COVID-19 positive. Local guidelines should be followed when making decisions. Detailed information for protection of patients and health care providers is provided in various websites, including the Centers for Disease Control (<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>) and the European Centre for Disease Prevention and Control (<https://www.ecdc.europa.eu/en/all-topics-z/coronavirus/threats-and-outbreaks/covid-19/preparedness-and-response-covid-19>).

In a COVID-19 negative or a low-risk patient

- > Ensure there is minimal patient movement around the hospital.
- > Meet the patient in a clean room with no prior exposure to COVID-19 positive patients.
- > Procedures should be carried out by an experienced person.
- > Ensure that the needed medications (for ITP refill) and equipment are ready and transported in a fully covered plastic bag. Open the bag with disposable gloves and take out the medications in a clean area.
- > These procedures do not lead to aerosol generation; hence contact and droplet precautions must be taken. Ensure an accessible hand-wash area and hand sanitizer are available.
- > Utilize surgical mask, eye protection, surgical gown, and double gloves for personnel involved in performing the procedure. The use of N95 or similar powered air-purifying respirator (PAPR) is not necessary.
- > The patient should wear a surgical mask to reduce the chance of droplet spread.
- > The device-programming equipment – particularly parts that come in contact with the patient such as ultrasound equipment and transducer – should be protected from contamination using plastic covers. Bringing carts or trolleys with drugs and equipment to the procedure room should be discouraged.
- > Minimize the number of personnel present during the performance of the procedure, but help should be readily available.
- > Routine aseptic technique should be followed. An in-vitro study suggests that COVID-19 virus particles are viable for longer on plastic than cardboard. A change in practice to use sterile paper drapes instead of these transparent plastic ones should be considered if available.²⁶

In a COVID-19 positive or a high-risk patient

- > Strictly limit these patients to urgent procedures.
- > The procedure or meeting should be performed in an area or procedure room designated for use with COVID-19 patients. This ensures that protective equipment is available and precautions are followed.
- > The use of common areas, such as a block room or a holding area, should be avoided as they can lead to contamination.
- > These procedures do not lead to aerosol generation; hence contact and droplet precautions must be taken. However, consideration of the use of N95 mask may be made on a case-by-case basis depending on local availability. This depends on the risk of coughing or sneezing by the patient.
- > Other precautions are similar to a low-risk patient.
- > Post-procedure or after the evaluation, the patient should be monitored in the room until they can be shifted to an isolation room (in hospital) or discharged home with instructions.
- > It has been shown that the risk of transmission is highest during the removal of protective gear; hence, appropriate precautions should be taken to remove and discard gloves and masks. It is essential that hands are washed thoroughly after the procedure and that physicians avoid touching their face or other surfaces beforehand.
- > The presence of an observer during the donning and doffing procedure is highly recommended. Simulation sessions for the donning and doffing of PPE should be conducted for training staff.

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16th ESRA Winter Week



Morné Wolmarans (Norfolk and Norwich University Hospital, UK) @docmorne

The 16th ESRA Winter week was again organised by **Jens Børglum** from Denmark and **Geert Jan van Geffen** from the Netherlands. They are two of the best regional anaesthetists that I know and feel privileged to call them friends. And this is exactly what the ESRA Winter week is all about! Making friends in perfect Austrian surroundings, with a fantastic balance of excellent regional anaesthesia (RA) education, the superb Aqua Dome Spa hotel in Längenfeld, the nearby ski slopes of Sölden and the very informal gatherings sharing ideas amongst RA friends.

The two remarkable aspects of this meeting is firstly the exceptionally high standard of RA education. Most of the delegates are proficient RA practitioners, so the level of detail and enthusiasm for teaching and learning is outstanding, but participants of all levels of RA ability is definitely catered for. The sharing of different practices, tips and tricks between faculty and delegates, ensures that the best level of safe RA practice is justified, discussed and challenged. This year 120 delegates from all over the world gathered for this 5 day meeting and discussed best practice that works for them in their country and hospital environment. We certainly learn from each other.



The second aspect that I love about this meeting, is the how the format and venue creates so many opportunities for informal discussion about RA. This could be during breakfast, coffee breaks, pre dinner aperitifs or the ski bus to Sölden. You could be in the 007 restaurant (Ice Q) at 3048 meters, discussing the use of Dexamethasone with **Eric Albrecht** and **Matthias Desmet** while comparing which Schnitzel is the best in Europe. Or get opinions on types of infraclavicular blocks from **Steve Coppens** in the spa, while Vladimir, the masseuse beats you with eucalyptus tree branches. Or drinking a Monkey 47 gin with **Jens Børglum** and comparing which Quadrates Lumborum Block is really the best and how shall we name it? Or standing in a hotel lift in wet swimming trunks and sandals, wishing you still had abdominal muscles like a six pack, discussing the benefits of fascial plane blocks with **Vincent Chan**. Yes! The Vincent Chan!! My point is that this meeting creates interactions with RA enthusiasts like non other and this is why more than 50% of the delegates return on an annual basis. So book early for next year!

3rd European Day: more than 1700 participants



Sébastien Bloc (Claude Galien Private Hospital – Quincy Sous Senart – Paris, France) @sebebloc

The third session of the European Day was again a great success, with more than 1700 participants from all over Europe, on 25th of January 2020.

European Day (E-Day, #ESRADAY) is the face to face meeting organized by ESRA the same day in several cities in Europe on the last week of January.

In each city, local experts and local organizers oversee an interactive day dedicated to sharing and transmitting knowledge in regional anaesthesia.

Short lectures, hands-on sessions, podcasts are proposed in an atmosphere of friendliness and interactivity.

Each year, experts address the hot topics during their 6 minutes interview, which are broadcasted to every participating city. Other topics are presented by local experts including hands-on workshops during the afternoon session.

Same day, same programme, local organization and local experts are the ingredients of the E-Day.

In 2020, 35 cities in 13 countries were involved in the E-Day.

https://esraeurope.org/wp-content/uploads/2020/03/EUDAY_List-of-Cities-pdf.pdf



More than 200 experts took part to share their knowledge and their enthusiasm. There will certainly be a city near you next year. So where will you come to join us to share some experiences?



The usual format is for each day of the week is an early breakfast and then a 2 hour session of short, detailed lectures from passionate experts. Jens and Geert-Jan's programme was delivered by internationally renowned speakers to cover a variety of topics including Chronic pain, RA, Obstetric anaesthesia and relevant interesting clinical topics.

So spoke **David Fertleman**, geriatrician about the mechanisms involved in the development of postoperative delirium. He gave details with humour and experience about the perioperative multidisciplinary care for the geriatric orthopaedic patient. Including how in daily practice we cope with the anaesthetic problems we might face with the growing amount of octarians presenting for orthopaedic surgery. **Athmaja Thottungal** spoke about the role fascia's may play as an important source of nociceptive input in different pain syndromes and discussed several interventional therapies. In another lecture she discussed the developments in ultrasound guided pain interventions.

Sarah Armstrong, obstetric anaesthesiologist updated the audience about labour analgesia, and how to provide effective analgesia after cesarean section. She provided tips and tricks how to approach and treat the obese parturient, an increasing group of patients in the obstetric practice. In Steve Coppens lecture, he discussed the options and benefits of providing regional anaesthesia for thoracic surgery.



Vincent Chan who has regularly supported this meeting and after a gruelling travel schedule, accompanied by his wife Ann, gave a though provoking lecture on minimal clinically differences in pain and reviewed the current evidence for fascial plane blocks. Geert Jan van Geffen spoke about and demonstrated POCUS skills.

And there was also fantastic contributions from **Jens Borglum**, **Eric Albrecht**, **Steve Coppens** and **Matthias Desmet**, covering topics like ERAS protocols, RA education, block additives and RA for vascular surgery.



The middle of the day is dedicated to recreational activities which for the majority of participants included donning ski gear and hopping onto a ski bus to local ski resorts like Sölden and Obergurgl. There are enough ESRA friends to find a ski group that suits your fitness, ability and lunch requirements. If the ski slope is not your forte, you had the fantastic spa facilities located in the Aqua Dome hotel, which included indoor and outdoor heated pools, gyms, saunas and steam rooms etc.

The afternoon sessions included hands-on ultrasound workshops and a variety of problem based learning (PBL) discussions. All delegates rotated through all the sessions which ensured that the group sizes were small enough for an interactive learning experience.

All the members of faculty shared their expertise during the workshop sessions, like Eric Albrecht, a fantastic skier who not only showed his ski-skills on the slopes but also his ultrasound skills in the workshops. He also presented an update on intralipid for LAST, brachial plexus blocks and discussed whether it is safe to apply regional anaesthesia in diabetes patients. Matthias Desmet and I, who are regular faculty members for ESRA winter week, discussed the latest literature regarding regional anaesthesia and how to measure competency in regional anaesthesia training. We also provided PBL's about conflict management in the OR and how to prepare for the EDRA examination.

The remainder of the evenings were spent in the hotel restaurant and bars, which delivered set courses of mouth watering dishes that caters for all tastes. The hotel also has many different lounges and a library available. ESRA arranged networking sessions that provided even more informal interactive time for all participants.

Jens and Geert-Jan provided a perfect venue, invited enthusiastic world expert faculty with a great programme and the participants were eager to learn, discuss and share knowledge, but the smooth running of this conference was due to the hard work of **Vivienne Penning**, the local course manager.

She kept the show on the road, sorted out technical hitches and was the liaison between delegates, faculty, hotel and ESRA. She did a fantastic job keeping the faculty on time and organised.

The ESRA winter week will again be organised for the 17-22 January 2021 and I would whole heartedly recommend that you register early for this truly unique RA conference.

Best wishes and stay safe!



ESRA Innsbruck Pain and Regional Anaesthesia cadaver



Peter Merjavy (Craigavon Area University Teaching Hospital, Northern Ireland, UK) @PeterMerjavy



Steve Coppens (Co-editor of ESRA Updates, UZ Leuven, Belgium) @Steve_Coppens



Andrzej Krol (St. George's Hospital, London, UK)

ESRA Pain and RA Cadaver Course Innsbruck 19-22 February 2020

Traditionally during the third week of February ESRA Cadaveric Pain and Regional Anaesthesia happened this year again in the beautiful city of Innsbruck, Austria. Both workshops have attracted 110 participants from 25 countries and offered state-of-the-art lectures, live scanning as well as cadaveric dissections and also offered needling the cadavers under real time ultrasound guidance.

Upon entering the magnificent old anatomy building in Innsbruck one can immediately appreciate the grandeur of this fantastic piece of art. All halls and theatres are filled with history and learning. It is impossible to not be impressed and everyone is anticipating this intense course with curiosity and expectance. (PIC)

The event was launched by Chronic Pain lectures and live model scanning on Wednesday afternoon. Dr Andrzej Krol from St George's University of London, and Dr David Lorenzana from Balgrist University Hospital in Zurich, introduced the international Faculty: Dr Luis Valdez and Dr Gustavo Fabregat from Spain, Dr Severine Burke from Switzerland and overseas contingent from the UK and Northern Ireland: Dr Raja Reddy, Dr Anthony Allan, Dr Peter Merjavy.



After short introduction lecture by Dr Krol, about application of ultrasound in chronic pain interventions and recommended literature, a real Giant stepped in: Professor Bernhard Moriggl of Department of Anatomy, Histology and Embryology of Medical University of Innsbruck has been the pillar of research and practical applications of ultrasound in regional anaesthesia and pain medicine for more than three decades. Each of Professor Moriggl relevant sonoanatomy lecture was followed by a short talk from the faculty members about clinical applications, practical tips and a live model scanning with two screens projecting ultrasound images and probe position.

Following morning eight practical workshop stations were set up. There were four clinical targets commonly seek in clinical practice:

- > Anterior neck: cervical roots (ventral rami of spinal nerves), “stellate ganglion” being middle cervical sympathetic ganglion and novel approach to suprascapular nerve under omohyoid muscle.
- > Lateral and posterior neck: greater occipital nerve, cervical medial branches, posterior approach to suprascapular nerve and shoulder structures itself.
- > Anterior abdominal wall: ilioinguinal, iliohypogastric nerves, both too common victims of herniorrhaphy, abdominal cutaneous nerves often overlooked cause of abdominal wall pain (ACNES), lateral cutaneous nerve of the thigh famous of causing meralgia paresthetica as well as periarticular injections to the hip and knee joint including its sensory branches (PENG block and genicular nerves blocks)
- > Lumbar spine and posterior pelvis shedding light on GPS (Gluteal Pain Syndrome), pudendal nerve and making caudal epidural and sacroiliac joint an easy target.
- > All four live model scanning stations were mirrored by the 4 cadaveric needling stations facilitating learning process. At each cadaveric station 10 min anatomical tutorial was provided on prosected specimen by a very knowledgeable and dedicated team of medical students carefully selected by Professor Moriggl and Dr Regina Irschick who were around to answer the most detailed anatomical questions. Anatomical knowledge refreshment was especially appreciated by delegates who visited anatomy lab for the first time since Medical School!

All rounded up in the evening at the Schindler Restaurant where the faculty, delegates and students entwined and were discussing and sharing their experience deep into the evening

If a reader of this newsletter already regrets missing the event, ESRA has introduced Cadaver Pain Workshops in a coordinated manner in the three different locations across Europe: Innsbruck, London, Madrid. Each course covers similar curriculum in a unique way related to the local specificity e.g cadaver embalming method, but always run by the top expert instructors approved by ESRA from all over the world. Mark your calendar for those events usually held in February, March and May each year respectively!

The following 2 days were entirely devoted to regional anaesthesia



Prof Paul Kessler (Frankfurt – Germany) introduced international faculty – Dr Steve Coppens (Leuven – Belgium), Prof Oya Yalcin Cok (Baskent – Turkey), Dr Dan Dirzu (Cluj Napoca – Romania), Dr Lukas Kirchmair (Schwarz – Austria), Dr Marcus Neumüller (Linz – Austria), Dr Slobodan Gligorijevic (Zurich – Switzerland) and Dr Peter Merjavy (Craigavon – UK).

Lectures on the first day focused on upper and lower limb blocks, highlighting alternatives to classical interscalene block (superior trunk block) and various techniques for reducing hemidiaphragmatic paralysis for shoulder surgery. Costoclavicular block and its anatomical similarity with previously used nerve stimulation technique – vertical infraclavicular block were discussed at length. Axillary brachial plexus block is still considered a good alternative for novices in RA.

After a filled day of fantastic workshops, state of the art lectures and social mingling in the coffee breaks it was time to enjoy the dazzling Innsbruck bars and restaurants to top of the day with perfection.



The second day brought us more intriguing and more controversial topics, like a discussion on truncal blocks. The underlying message was that in appropriate hospital setting with high volume cases thoracic epidural analgesia and thoracic paravertebral block have still their place as the current evidence still supports their use.

Common issues of various fascial plane blocks are legion. Poorly defined point of injection. Vague criteria for successful, failed blocks and misuse of anatomical terminology (e.g. interfascial plane block is used for injection between fascia and bone ...etc).

However truncal blocks have also revolutionized regional anaesthesia. Eventually the truncal thoracic and abdominal blocks created an interesting discussion about the anatomical base for various commonly used blocks, defining the fascia and interfascial plane, where all the delegates and faculty joined in.

Several techniques on how to prolong the duration of nerve blocks were also discussed including various additives, extended release preparations for local anaesthetics and NSAIDs as well as tips and trick for use of continuous catheter techniques with PCRA, intermittent boluses or continuous infusion of LA.



One of the highlights was the live scanning by Prof Moriggl. Being the knowledgeable anatomist that he is, he emphasized and stressed the importance of landmarks even in this age of ultrasound. With a simple explanation of the points of interest he demonstrated that he does not have to look for nerves, it's simply there and immediately in view if you know your landmarks.



I think in the future we might even make some new workshops, where experts emphasize on anatomy and landmarks and can draw the complex anatomy on the body before they scan.

All Innsbruck workshops created very positive atmosphere for discussion and strengthened the position of cadaveric courses in current education in regional anaesthesia.

Thanks to Prof Bernhard Moriggl and his team from Anatomy Institute Innsbruck, Prof. Paul Kessler – Chair of ESRA workshops and Morgane Lanoy with Vivien Penning (ESRA & Kennes) everything was running very smoothly.



Those preparing for EDPM or EDRA will find the courses very valuable in refreshment in anatomy, sonoanatomy for regional anaesthesia and various chronic pain syndromes.

PROSPECT's Corner



Marc Van de Velde (Chair of PROSPECT, UZ Leuven, Belgium) @MarcVandeVelde6

Why PROSPECT?

Effective analgesia is essential for optimal patient recovery after surgery (Joshi et al 2014; Lee et al 2018) but postoperative pain continues to be poorly managed in clinical practice (Gan et al 2014; Gerbershagen et al 2013). The PROSPECT initiative aims to provide healthcare professionals with practical recommendations for pain management in common but potentially painful operations.

PROSPECT recommendations for each intervention are formulated after careful evaluation of:

- > Procedure-specific evidence, based on a systematic review of the literature
- > The risks and benefits of the intervention in the specific surgical setting
- > Use of the intervention in the context of multimodal, non-opioid analgesic strategies and modern peri-operative care pathways.

The PROSPECT website (esraeurope.org/prospect) offers:

- > Accessible, practical and pragmatic advice on peri-operative pain management
- > Evidence-based arguments for and against the use of analgesic interventions
- > Translations of the summary recommendations in six languages.
- > Links to all the PROSPECT publications (most are open access)

Recent PROSPECT publications and recommendations:

- > **Just Released!** Oncological breast surgery: Jacobs A, et al. *Anaesthesia* 2020; 26 January.
- > Rotator cuff repair surgery: Toma O, et al. *Anaesthesia*. 2019;74:1320–1331.
- > Laparoscopic sleeve gastrectomy: Macfater H, et al. *World J Surg*. 2019;43(6):1571–1580.
- > Haemorrhoidectomy: Sammour T, et al. *World J Surg*. 2017;41(2):603–614.
- > Laparoscopic hysterectomy: Lirk P, et al. *Reg Anesth Pain Med* 2019;44(4):425–436 and a 2020 literature update
- > Laparoscopic cholecystectomy: Barazanchi AWH, et al. *Br J Anaesth*. 2018;121(4):787–803.
- > PROSPECT methodology: Joshi GP, et al. *Anaesthesia* 2019;74:1298–1304.
- > The PROSPECT initiative: Beloeil H, et al. *Anaesth Crit Care Pain Med*. 2018;37(4):305–306; Lee B, et al. *Best Pract Res Clin Anaesthesiol*. 2018;32(2):101–111.

Coming soon in 2020!

NEW PROCEDURES	UPDATES
Tonsillectomy	Open abdominal hysterectomy
Complex back surgery	Hernia repair
Laminectomy	C-section
Bunionectomy	Total hip arthroplasty
Hepatectomy	Total knee arthroplasty

Also underway: Prostatectomy, Craniotomy, Open Heart Surgery, Appendectomy, Oesophagectomy, Hip fracture, VATS, Open thoracotomy update

PROSPECT is supported by an unrestricted grant from the European Society of Regional Anaesthesia and Pain Therapy (ESRA).

<https://esraeurope.org/prospect/>

Interview with Patrick Narchi



Clara Lobo (Editor of ESRA Updates; Cleveland Clinic Abu Dhabi, UAE) @claralexlobo



“ The anesthesiologist should become the real manager of an efficient operating theatre. ”

ESRA Updates: Can you give us a brief summary of your career?

Patrick Narchi: Finished my residency in anesthesia in Paris (Bicetre University) in 1987 where I started practicing regional anesthesia. In 1992, I moved to a private hospital in Le Mans till 1996. Then I moved to Lebanon during 5 years and worked at the University Hospital (Hotel Dieu Hospital). In 2002, I came back to France where I am working at present in the private sector again: Centre Clinical in Soyaux, France.

ESRA Updates: Was Anaesthesiology your number one choice? If not, what was? If yes, why anaesthesiology?

Patrick Narchi: Anesthesia was my first choice. Surprisingly, I chose Anesthesia because it was the only way to train in Intensive Care (which was my personal preference initially). The 2 diplomas are linked together. Then, rapidly, I moved away from Intensive Care to Anesthesia and then started research in regional anesthesia

ESRA Updates: What was your boldest career move?

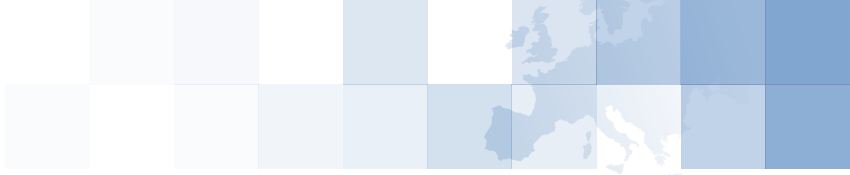
Patrick Narchi: Very probably, it was in 1992 when I decided to leave the university in Paris to start working in the private sector with an enthusiastic goal (shared with some friends working in other private hospitals) of opening the private sector to Education and clinical research.

ESRA Updates: Looking back, what was the worst mistake in your career?

Patrick Narchi: Having only 2 children ... I would have loved having 2 others.

ESRA Updates: Can you share the most memorable moments of your career?

Patrick Narchi: My first talk inside an impressive ballroom at the ASRA meeting in 1996 in San Diego. I was just 36 years old! My lecture was a refresher course focusing on the use of nerve stimulators for nerve blocks in a country (USA) where nerve stimulation was not officially encouraged!



ESRA Updates: What is your most appreciated character in history, and why?

Patrick Narchi: Winston Churchill, for his pertinent strategic views and ... his sense of humor.

ESRA Updates: Do you have any apologies that you would like to ask?

Patrick Narchi: I would like to apologize to my family, as a majority of my friends in ESRA, because I have been frequently absent during my career.

ESRA Updates: What single unheralded change has made the most difference in your field in your lifetime?

Patrick Narchi: Pulse oximeter for safety in Anesthesia, and also nerve stimulators which made regional nerve blocks much easier to teach and to spread worldwide.

ESRA Updates: What new technology or development are you most looking forward to?

Patrick Narchi: Improving 3D simulator technology to facilitate teaching regional anesthesia.

ESRA Updates: What book should every doctor read?

Patrick Narchi: Anything else than Medicine! Unfortunately, Medicine is so demanding and evolving that frequently, doctors do not have enough time to read novels, biographies, etc ... we should also devote some time to reading outside medicine.

ESRA Updates: What is your favorite movie?

Patrick Narchi: The Godfather.

ESRA Updates: How do you spend your free time?

Patrick Narchi: Reading novels, sports and gardening.

ESRA Updates: What is your guiltiest pleasure?

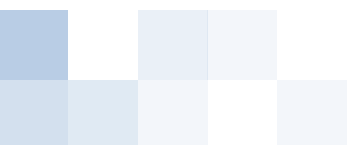
Patrick Narchi: Tasting foreign cuisine and nice cigars!

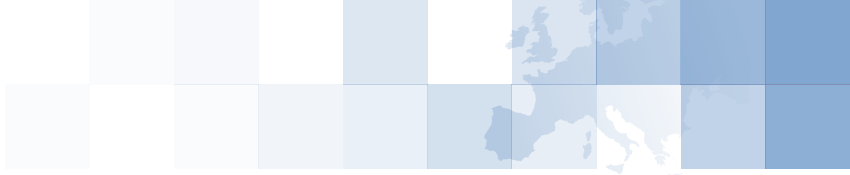
ESRA Updates: When were you happiest?

Patrick Narchi: Every time I am facing the Mediterranean sea ...

ESRA Updates: What personal ambition do you still have?

Patrick Narchi: The anesthesiologist should become the real manager of an efficient operating theatre. This is already the case in very few hospitals today but remain a realistic challenge for the future. We are not only OR technicians!





ESRA Updates: If you were given 1 million euros what would you spend it on?

Patrick Narchi: Teaching regional anesthesia and pain in underdeveloped countries. There is still so much to do there!

ESRA Updates: What are three features you mostly value on people and three you dislike?

Patrick Narchi: 3 features I mostly value: sincerity, fun, modesty. 3 features I dislike: arrogance, unfairness, laziness.

ESRA Updates: You are currently the chair of ESRA's Ambassador Program. What is your personal view of this program? What would you consider your greatest achievement?

Patrick Narchi: While the Core of ESRA remains Europe (where we are still including new countries such as Ukraine, Bulgaria, North Macedonia, Hungary, Czech republic ...), we should open our society to friends outside Europe who are willing to join and cooperate with ESRA. We have already signed in October 2019 our first cooperation agreement with South Africa. Other countries have been approached and we are ready and happy to support such sister societies through our ambassador program to implement this cooperation.

ESRA Updates: If you had a crystal ball, how do you see ESRA in 10 years?

Patrick Narchi: Definitely bigger, much more international and still very friendly!



Interview with Fellow Harry Thompson



Nuala Lucas (Co-Editor of ESRA Updates, Norwick Park Hospital, Harrow, UK) @noolslucas



“ I always leave work feeling like I have added to my skillset and experience. ”

ESRA Updates: Tell us a bit about your career so far?

Harry Thompson: I graduated in London in 2008. After various detours along the way, including some time in the military, I am now an ST6 Anaesthetic Trainee in Central London. I am undertaking my first advanced module in regional anaesthesia as one of the two fellows in the University College London Hospital. I work in the regional block room which provides a regional service for a large theatre complex.

ESRA Updates: Why did you want to do a fellowship in regional anaesthesia?

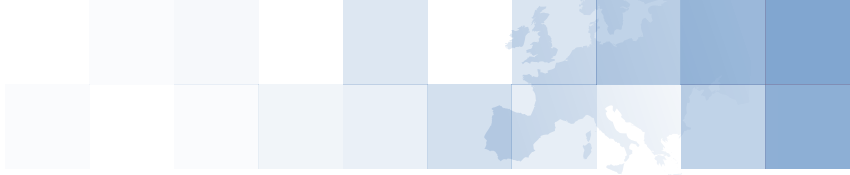
Harry Thompson: I have always loved being involved when regional techniques have worked well and saved unplanned overnight stays, cancellations and even avoided ITU bed occupancy. I knew that I wouldn't feel like I was doing my best by patients unless I was able to offer them these procedures. I knew that whatever subspecialties I ended up doing, this fellowship would be useful.

ESRA Updates: What are the benefits of doing a dedicated fellowship rather than a simple placement?

Harry Thompson: As a fellow, you get treated more like a junior consultant. You are given management responsibilities and formal teaching slots. We organise courses, are involved in purchasing through company representatives and we introduce new systems into the patient pathways. Protocols, research and QI projects are all thrown at us. It is more difficult learning to say no to things than to find worthwhile projects to be involved with. You can make a real impact and also improve your application for consultant jobs; it strengthens your experience in the non-clinical aspects of our jobs.

ESRA Updates: What makes up a typical day for a regional fellow?

Harry Thompson: I attend the morning handover and see which of the emergency patients may benefit from a block. I then look at all the 15 theatre lists and, along with a the very experienced and efficient block room ODP, we come up with a plan and a patient order for our morning. We aim to have patients ready for their



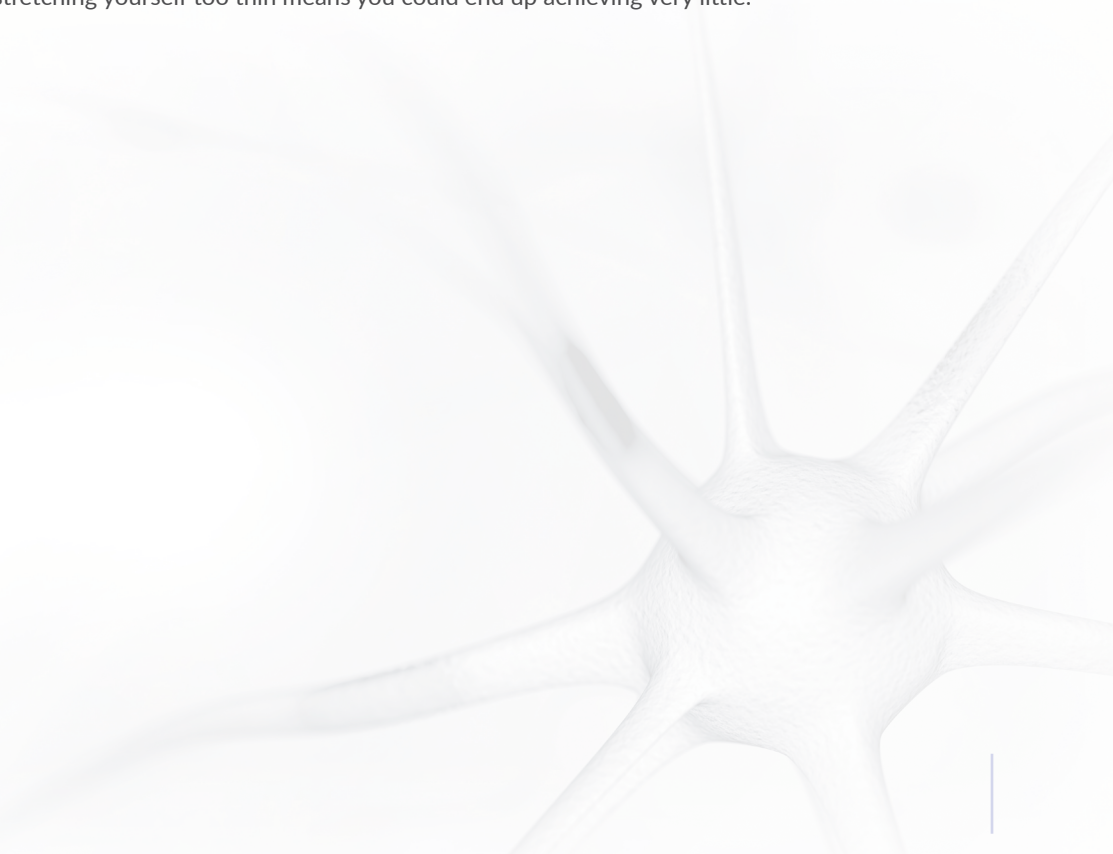
surgery before the theatre is ready for them to improve throughflow and productivity. I perform between 5 and 10 blocks in a typical morning. We cover all sorts of surgery types, so the experience is broad. I always have a consultant supervisor in the theatre complex to ask for help with less common blocks or tricky sonoanatomy or sedation. In the afternoons, I am usually in an orthopaedic list which leads to a handful more blocks and even some airway management! We have dedicated research/management/teaching time which is great because we can achieve so much more without compromising on time with friends or family. We can make meaningful changes over our year there. I like to get the more junior anaesthetists involved with poster presentations and audit work because we can achieve so much more by working together and it helps them with specialty training applications in the future. I always leave work feeling like I have added to my skillset and experience. It is immensely satisfying to become somewhat proficient at something that was a complete mystery to me beforehand.

ESRA Updates: Is it difficult to get accepted for a fellowship?

Harry Thompson: The good programmes, especially those with a dedicated regional block room, do tend to be popular in the UK. We had to be shortlisted to attend an interview, but the panel were very friendly. Fortunately, they were not looking at my level of previous regional experience. The fellowship is there to teach you that. Generic skills and attitudes are more important in making you a strong candidate. Some evidence of dedication to the sub-specialty is important too. Knowing when jobs are advertised and knowing when jobs were not filled is very important, especially if you are trying to fit in the fellowship around your formal training programme.

ESRA Updates: Any advice for someone about to start a fellowship in regional anaesthesia?

Harry Thompson: Throw yourself in and take every opportunity you can to learn from different mentors. I found that each consultant worked differently. It is nice to build your own approach by picking out the bits of style that suit you. Get ready to be overwhelmed with project ideas and teaching requests. Make sure you are careful about what you take on because stretching yourself too thin means you could end up achieving very little.



EDPM



Sam Eldabe (Chair of EDPM, The James Cook University Hospital Middlesbrough, UK)



Jose de Andres (Hospital General Universitario de Valencia, Spain)



Eric Buchser (Lausanne University Hospital, Switzerland)

a. The ESRA EDPM Examination. How to prepare:

What do you need to study?

ESRA EDPM is an exam aiming to assess clinical skills in pain medicine practice. The questions are, in the majority, based on clinical and procedural knowledge. However, since clinical knowledge is underpinned by a good understanding of basic sciences both parts of the exam will probe the candidate's knowledge of anatomy, physiology and pharmacology and, on occasion, pain ethics and research trials.

Where can you find the information?

While textbooks are an invaluable source of knowledge, they often contain outdated information, particularly in areas where science and clinical practice advance at a rapid pace.

The best way to prepare for both parts of the examination is to read and digest recent review articles on specific pain conditions and pain mechanisms in general. Some examples of these are below:

- > Goh EL, Chidambaram S, Ma D. Complex regional pain syndrome: a recent update. *Burns Trauma*. 2017;5:2.
- > Lavand'homme P. Transition from acute to chronic pain after surgery. *Pain*. Apr 2017;158 Suppl 1:S50-S54.
- > Farooq K, Williams P. Headache and chronic facial pain. *Continuing Education in Anaesthesia Critical Care & Pain*. 2008;8(4):138-142.

Other high-quality source of revision material is the IASP Clinical Updates publications or the British Journal of Anaesthesia CPD resources. See examples below

- > Schug SA, Bruce J. Risk stratification for the development of chronic postsurgical pain. *Pain Rep*. Nov 2017;2(6):e627.
- > Pain after Amputation. MJE Neil, FRCA FFPMRCA .*BJA Education*, Volume 16, Issue 3, March 2016, Pages 107–112, <https://doi.org/10.1093/bjaed/mkv028>.

b. The Multiple Choice or Part I EDPM Examination:

The MCQ exam will consist of 60 True false MCQ questions.

Below two examples of clinical and basic sciences questions.

Q1. A 32-year-old lady complains of a recent onset of severe neck and right shoulder pain her MR scan shows a right sided C6/7 disc protrusion with no nerve compression:

- A. A right C6 nerve root block is clinically and ethically justified
- B. A cervical interlaminar epidural is justified
- C. A cervical X Ray is required
- D. A cervical nerve root block should avoid the use of particulate steroids
- E. Radiofrequency denervation of the right C5 dorsal root ganglion is an appropriate intervention

Answers:

- A. False the symptoms are more consistent with a C5 root distribution and there is no evidence of nerve compression
- B. False in the absence of nerve compression the risks are unjustified
- C. False unlikely to provide further information
- D. True
- E. False

Q2. A- δ fibers:

- A. Are myelinated
- B. Are low-threshold mechanoreceptors
- C. Increase their firing as the intensity of the stimulus increases
- D. Do not respond to noxious stimuli
- E. Are thick nerves

Answers:

- A. True
- B. False
- C. True
- D. False
- E. False

c. The Viva or Part II EDPM Examination:

The Viva Exam consist of two five-part questions with the top question based on a clinical scenario and following questions on pathophysiology, pharmacology, pain procedures and a pain syndrome. Question heading cover different topics in order to give candidates whose practice may not expose them to particular area of practice a fair chance. Candidates are however expected to possess sufficient theoretical knowledge to enable them to attempt all five parts.



An example of a viva question is below for guidance.

Q1. A 67-year-old man is referred with bilateral foot and calf burning pains worse in bed at night. Pains are improved on sitting but worsened on walking. The pain stops him from walking more than 15 meters on the flat. You will be asked about the differential diagnosis.

What is your differential diagnosis?

- A. Peripheral vascular disease or critical limb ischaemia
- B. Night cramps
- C. Neurogenic claudication (spinal stenosis)
- D. Diabetic neuropathy
- E. Arthritis of foot joints

On examination he has mottled feet with purple discolouration of the tips of several toes. He has a small ulcer on the side of the fifth toe foot pulses are absent bilaterally.

What is your diagnosis? What questions would you wish to ask the patient?

- A. Critical Limb ischaemia.
- B. Risk factors: hypertension, ischaemic heart disease, smoking, diabetes
- C. Has he seen a vascular team?
- D. Past treatment

The patient shows you a letter from vascular surgery explaining that he has a femoropopliteal graft 10 years ago and further surgery is not recommended. He is due to start oral warfarin. What treatment would you recommend?

- A. Analgesia: (candidate needs to be able to classify and discuss analgesics with some guidance into simple analgesics, moderate strength opioids, and adjuvants and strong opioids?)

Of relevance is the interaction of analgesics with anticoagulants such as warfarin which are used commonly in this group (warfarin effects decrease with carbamazepine and increased by celecoxib, diclofenac, duloxetine, etodolac, meloxicam, naproxen, paracetamol, venlafaxine)

- B. Address and correct risk factors, if possible.
 - C. Chemical Lumbar sympathectomy (role not well established and not evidence-based but practiced as palliation), risks include long term genitofemoral neuralgia
 - D. Spinal Cord Stimulation (some evidence-based data suggest improved pain control and limb salvage but RCT contradictory), Cochrane review suggests that Spinal Stimulation produces best results when guided by Transcutaneous PO2
 - E. Amputation with pre-emptive analgesia such as epidural infusion, sciatic perineural infusion and continuous spinal infusion.
- > **Discuss the pathophysiology of chronic post-surgery pain**
 - > **Discuss the indication, dosage and adverse effects of carbamazepine**
 - > **Describe a technique and indications for pudendal nerve block**
 - > **Compare and contrast addiction vs physiological dependence**

Good Luck to all and see you in Thessaloniki!

On behalf of The EDPM Faculty