State of the Art Safety Standards in RA
THE EUROPEAN SOCIETY OF REGIONAL ANAESTHESIA & PAIN THERAPY

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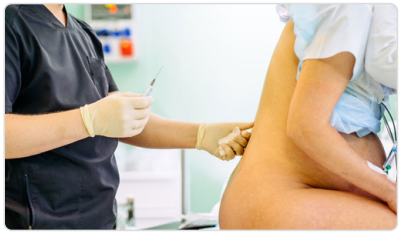

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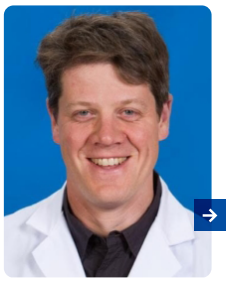

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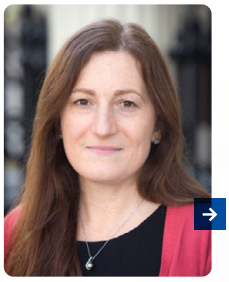

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Editorial

Thomas Volk (ESRA Past-President, Germany) @ThomasVolk16

" I personally want to thank all colleagues from 84 countries who registered and faithfully attended and to the 99 speakers who generously sacrificed their spare time and shared their knowledge. "

Annual Congress 2021

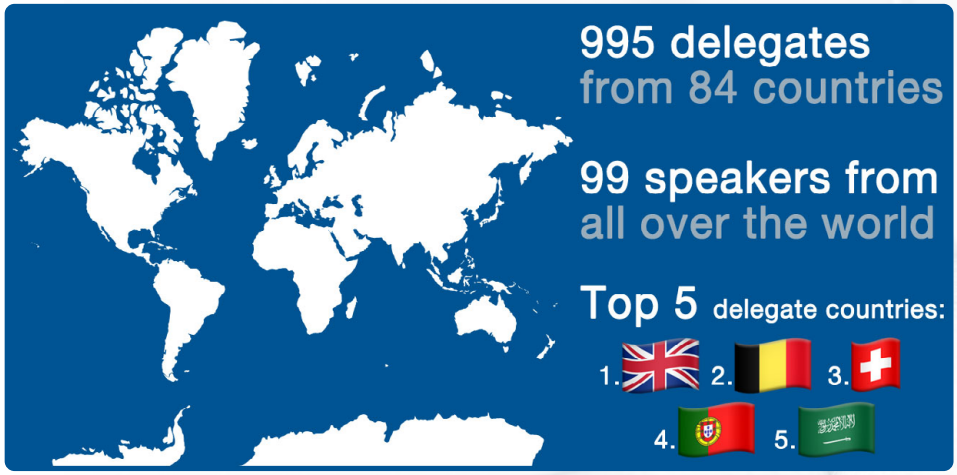
Dear friends and colleagues,

I'm sure you well remember our competition about how unpleasant year 2020 was due to CoViD-19 pandemic and how much most of us hoped that 2021 would be a much more positive year, full of high expectations of returning back to "normality". In fact we in ESRA board, have struggled to make the right decision until the very last minute to go for fully virtual congress in order to succeed and offer a high quality event, overcoming the current situation in Europe and across the world.

ESRA takes education very seriously and on 8th September we introduced an open forum day, free of charge for everybody. This day was highly attended, recognizing the mastery of speakers and quality of the topics discussed.

The main congress was held in 3 parallel online "tracks" on 9th – 10th September, starting early morning and lasting the whole day.

I personally want to thank all colleagues from 84 countries who registered and faithfully attended and to the 99 speakers who generously sacrificed their spare time and shared their knowledge. I particularly acknowledge those speakers and participants out of Europe, in various time zones, who kept awake in the middle of the night.



Each congress day ended with a “wrap up” session, summarizing the most important impressions, highlights and messages of the different tracks.

E-Posters were presented throughout the congress and are now published in RAPM journal (*see here*).

Remember to get your CME credits from virtual ESRA conference and please don’t forget to fill in our online survey. Your opinion is much important too ESRA and we would greatly appreciate if you’d let us know what can we improve in 2022, when we will meet in sunny Thessaloniki.

Last, but not least, let me introduce you the winners of the prestigious ESRA Carl Koller Award and Recognition of Education Award 2022: Prof. Dr. José de Andres and Priv.-Doz. Dr. José Aguire, respectively.

Prof. Dr. José de Andres (left) & Priv.-Doz. Dr. José Aguire (right)

East Surrey Regional Anaesthesia Course

Catherine Allen (Regional Fellow, Surey and Sussex Healthcare NHS Trust - Redhill, UK) @eastsurreyRA

Venkat Duraiswamy (Consultant Anaesthetist, Surey and Sussex Healthcare NHS Trust - Redhill, UK) @drvenkat

> “ Organising an event of this magnitude, fraught with the complications of an ongoing global pandemic, was challenging but ultimately very rewarding. ”

After such a long period of events being cancelled or alternatively in online format, it was wonderful to welcome delegates to the 2021 East Surrey Regional Anaesthesia Course. This was the first course able to be run in the UK for regional anaesthesia since the beginning of the pandemic. The last East Surrey Regional Anaesthesia course had been run in February 2020 just before the first lockdown. Organising an event of this magnitude, fraught with the complications of an ongoing global pandemic, was challenging but ultimately very rewarding.

COVID-safety was at the forefront of the organisation of this event. National guidelines were implemented; masks were mandatory and hand sanitising stations set up. Due to the restrictions at the time we were only able to welcome delegates from across the UK. We will, however, look forward to when we are able to once again invite delegates from around the world. As clinical practitioners all the delegates were dual vaccinated. Model volunteers were theatre staff and anaesthetic trainees and as such were also double vaccinated.

«COVID-safety was at the forefront of the organisation of this event.»

Day one was focused on anatomy with an exploration of pro-sections under expert guidance at Brighton and Sussex Medical School. Days two and three were hosted at the Holiday Inn hotel in Gatwick, with ultrasound demonstrations on models. We were also able to provide live demonstrations of blocks from theatres streamed on a secure server. The hotel and medical school had also implemented their own COVID-safe working guidelines which were strictly adhered to. Learning was in small groups accompanied by demonstration by those expert in regional anaesthesia to illustrate learning points and hints and tips for optimal success. One modification that was made was as an alternative to the simulation sessions usually on offer; these sessions were pre-recorded

and presented to delegates on individual memory sticks. This cut down the interaction and potential exposure to COVID-19 that may have been facilitated with the use of a limited amount of equipment. Ideally once it is feasible to we would like to use interactive simulation as a teaching tool once again, as this is a method of teaching proven to be very effective. This was a good alternative to utilise in the circumstances.

Despite the anxieties around returning to a face to face practical course the feedback received was outstanding. It was clear that delegates very much enjoyed the hands-on learning, something that is not easily replaced by online or distance learning. In addition, as the cadaver workshop is a mandatory element of the EDRA examination we were pleased to be able to offer this once again. In summary, despite obstacles the running of this course in its current format was able to minimise risk whilst maximising learning, networking and enjoyment.

Many thanks to all faculty and volunteers who worked hard to make this event a great success.

From left to right: Dr. Wolmarans, Dr. D B-St.Laurent & Dr. Krol teaching and performing blocks.

ESRA Educational Grant – Our experience from St George's University Hospital


Georgia Efstathiou (ESRA Fellow, Chelsea and Westminster Hopital NHS Trust)


Andreas Kostroglou (ESRA Fellow, Liverpook Women's Hospital NHS Foundation Trust)

" We are immensely grateful for this 3-month training and would like to encourage fellow anaesthetists to apply for the ESRA Educational Grant. "

During our anaesthetic training in Greece , we have realized how important regional anaesthesia proved to be for our daily clinical practice. There is nothing more satisfying than being able as an anaesthetist to deliver the best analgesia to patients. Therefore, we had a personal goal to visit a department that offers an advanced training in regional anaesthesia; we achieved this goal by successfully applying for the ESRA Educational Grant. During our research we realized that St George's University Hospital in London would be ideal, since it is a major trauma centre with an extensive regional anaesthesia curriculum. We contacted Dr Andrzej Krol (Regional Anaesthesia Lead and Program Director) who has kindly accepted us for a 3-month training. We were thrilled to start working in a centre of excellence in regional anaesthesia.

To be honest, our experience in St George's exceeded our expectations. St George's Hospital, founded in 1733, is one of the UK's largest teaching hospitals and one of the largest hospitals in Europe. As a major acute hospital, St George's Hospital also offers specialist care for the most complex injuries and illnesses, including trauma, neurology, cardiac care, renal transplantation and cancer care. The Anaesthetic Department has 140 consultants and 40 trainees. There are 30 operating theatres with a lot of ultrasound machines. There, we had the opportunity to perform a wide variety of peripheral nerve blocks (upper, lower limb, trunk blocks) and to build up our skills in peripheral nerve catheters insertion. What raised our interest particularly, was the specific clinical pathway for patients undergoing major limb amputations, where the sciatic nerve catheter was inserted in more than 90% of the patients and was kept for at least 5 days, reflecting the high quality of regional analgesia that is provided in this hospital. It was also valuable learning for us working within the acute pain team and learning the pathways of providing post-operative analgesia for the patients. We felt honoured being active members of the Regional Anaesthesia Team, at St George's hospital.

From the left: Dr Martin Marinov, Consultant in Anaesthesia and Pain Medicine, Dr Georgia Efstathiou ESRA Fellow, Dr Andrzej Krol, Consultant in Anaesthesia and Pain Medicine

Except for our clinical practice, Dr Krol assigned us with several projects, such as writing a patient information leaflet for the ambulatory spinal and upper limb blocks for Day Surgery, to undertake an oral presentation in the department about Acute Compartment Syndrome and Regional Anaesthesia and to make a quality improvement survey on the safe practice of regional anaesthesia. Also, we had the opportunity to practice several procedures in the pain clinic, such as performing lumbar, caudal epidurals, diagnostic peripheral nerve blocks and RF and facet joints/ medial branch blocks. Furthermore, we had the chance to attend the first hand on course on regional anaesthesia after the pandemic, organised by the faculty of East Surrey Hospital in collaboration with the Anaesthetic Department of St George's Hospital. It was an excellent 3-day course which included a cadaver workshop, an ultrasound demonstration workshop and live interactive demonstration from theatres run by very enthusiastic, knowledgeable and helpful faculty.

From the left: Andreas Kostroglou, ESRA Fellow, Georgia Efstathiou ESRA Fellow, Dr Georgios Giannitopoulos, Consultant Anaesthetist

At St George's hospital, we found a very pleasant working environment. The consultants were always very patient and available to teach us even after long and demanding days or under stressful situations. Moreover, the trainees and trauma/regional fellows were very friendly and their support was invaluable throughout our training. All the other doctors, nurses, the acute pain team and the administration staff were also very kind and welcoming.

We made strong relationships during this 3-month period and we are very grateful to all the anaesthesia staff, and particularly to Dr Krol, our mentor, for ensuring that this opportunity was rewarding and meaningful to us, for all the advice and encouragement and for making our training so pleasant.

We are immensely grateful for this 3-month training and would like to encourage fellow anaesthetists to apply for the ESRA Educational Grant. By taking part in such a programme, apart from the extensive training in regional anaesthesia, anaesthetists are able to build a professional network across countries and experience different working environments and healthcare systems.

Finally, we would like to thank the ESRA team for all the work they did to make this opportunity possible, even during a world pandemic, and for the support they provided throughout our placement. We are also very grateful to our colleagues in the previous department where we completed our training (Attikon University Hospital of Athens) for supporting us during our residency and giving us the essential credentials in order to be able to apply successfully for the ESRA Educational Grant.

Converting labour epidural analgesia for caesarean section – results of an ESRA 2021 poll!

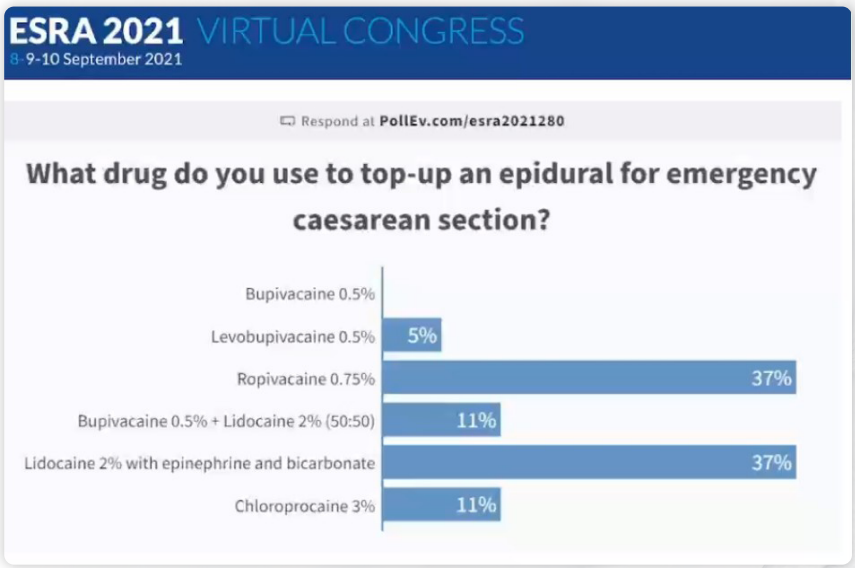

Nuala Lucas (Co-Editor of ESRA Updates, Norwick Park Hospital, Harrow, UK) @noolslucas


Andreas Kostroglou (ESRA Fellow, Liverpook Women's Hospital NHS Foundation Trust)

" This snapshot survey provides an interesting insight into practice in this area. We hope to repeat the poll at future ESRA meetings. "

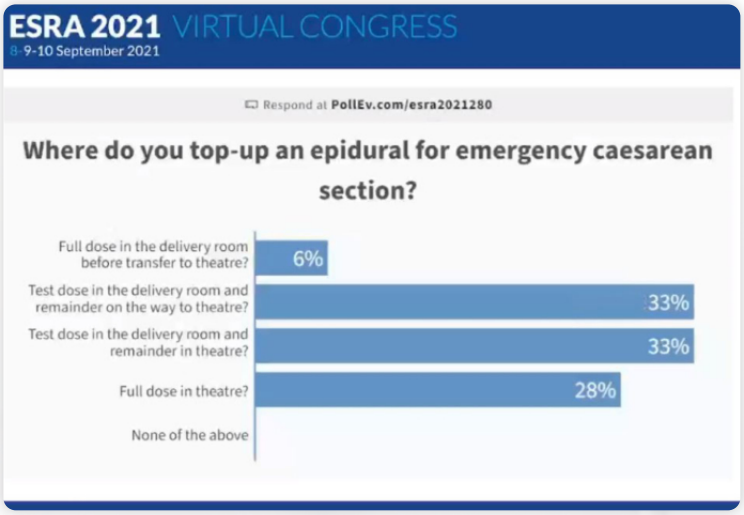
Converting labour epidural analgesia to surgical anaesthesia for emergency caesarean section is commonly undertaken on the labour ward. The main goals for the anaesthetist are to convert analgesia to anaesthesia as rapidly and safely as possible to assist with minimising the decision to delivery interval and secondly to ensure that the woman has a comfortable experience. If not managed appropriately, intraoperative breakthrough pain can have serious psychological sequelae for a woman and is an important medicolegal issue in obstetric anaesthesia. The best way to convert labour epidural analgesia to anaesthesia in this situation remains unclear. Several randomised controlled trials have examined the efficacy of different local anaesthetic solutions and adjuncts, but none has clarified the optimal approach. Opinion remains divided about the choice of local anaesthetic, where to administer the epidural top-up and whether opioids should be routinely used as part of the top-up on this situation.

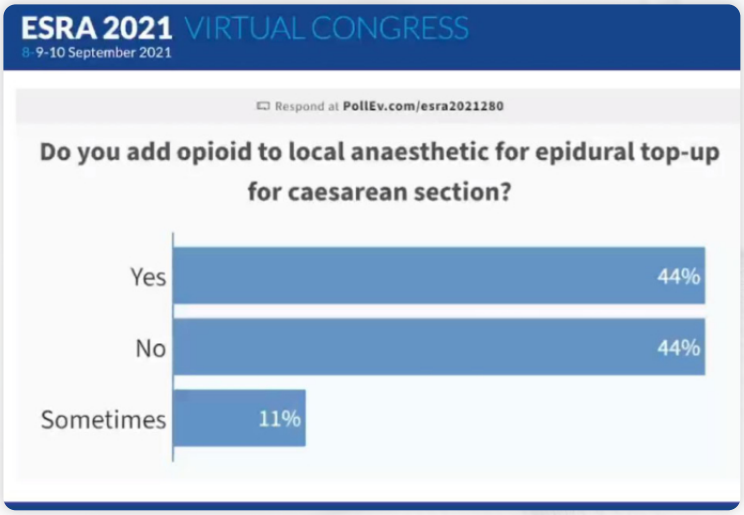
During ESRA 2021, a well-attended session discussed this problem. The high-quality platform used for ESRA 2021 enabled live polls to be conducted during the sessions. We used this facility for polling delegates on their strategies around labour epidural conversion for emergency caesarean section, including choice of local anaesthetic, where the top-up is administered, and lastly, whether they routinely use an opioid as part of their top-up strategy.



Most ESRA delegates used ropivacaine 7.5mg/ml or a lidocaine/adrenaline/bicarbonate solution to extend labour analgesia, suggesting a practice supported by a recent network meta-analysis. Most respondents initiated the top-up in the delivery room and administered the remainder either en route to theatre or once the woman had arrived in theatre, suggesting a desire to balance reducing anaesthetic time (and therefore decision-to-delivery interval), alongside prioritising maternal safety. Regarding whether opioids were added routinely to the local anaesthetic top-up, the delegates were equally split on this question, with a small percentage only occasionally adding opioids to the local anaesthetic top-up.

This snapshot survey provides an interesting insight into practice in this area. We hope to repeat the poll at future ESRA meetings. Our thanks to Eleni, Thomas, Alain, and Clara and the whole ESRA team for their efforts in putting on a fantastic and innovative meeting!





Most attended sessions of ESRA Virtual Meeting 2021


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


Andreas Kostroglou (ESRA Fellow, Liverpook Women's Hospital NHS Foundation Trust)

> " The adhesion was massive, from the four corners of the world! All feasting their eyes and controlling their drooling, while watching the scientific sessions, adorned by the most inspiring speakers. "

This year, ESRA chose to go virtual, since the conditions that would allow both the organization of large face-to-face events and speakers / participants travelling without restrictions were not met. This was caused by rising of COVID-19 cases in various European countries.

We opened and closed this congress to the tones of Ludwig van Beethoven's 9th Symphony "Ode to Joy", which you can enjoy by clicking here whilst you carry on reading our newsletter.

The attendance was massive. We have welcomed the participants from all corners of the world with more than 1700 participants registered during the 3 days of congress. For 3 whole days (1 day open forum and 2 days online congress) there was a unique close connection between ESRA and its associates / delegates. The feedback received was excellent, both by the participants and by the speakers.

In total, the time spent online by all participants for open forum day was over 1144 hours and for the online congress 3395 hours. We have also identified the 5 countries with the highest number of participants online: United Kingdom, Belgium, Switzerland, Portugal and Saudi Arabia.

During every congress there are some sessions more popular than others. There are many reasons for this popularity, but just to name a few: relevance / novelty of the topic, latest research, applicability for daily clinical practice, eloquent and knowledgeable speakers or practical tips "how I do it".
Traditionally, in order to guarantee the place in the room one needs to get there quite early, some will actually put the alarm on their phones as a reminder of the session. Just to get a chair in the room for the most popular sessions. Online meeting allows everyone attend any session as there are no limitations for participants numbers in online world.

Top 10 countries of origin

United Kingdom	182
Belgium	76
Switzerland	70
Portugal	67
Saudi Arabia	54
Netherlands	53
No Country	52
Australia	42
Ireland	31
France	30
Germany	30

The most popular sessions of this congress were as follows:

Open forum day sessions
- RA Career Opportunities
- Education and training in RA, the next level
- Cadavers for RA hands-on training.

Congress sessions
- Pitfalls during US guided blocks: All the structures you should not miss. All steps clear?
- Update on thoracic blocks
- RA & antithrombotic agents: A literature update
- RA and the difficult patient
- Point-of-care ultrasound (POCUS): Unnecessary gadgetry or evidence-based medicine?.

Top 3 Sessions Open Forum Day

Time	Session	Attendance
14:10 - 15:40	RA Career Opportunities	363
09:20 - 10:50	Education and training in RA: The next level	344
16:30 - 18:00	Cadavers for RA hands-on training	301

Top 10 Sessions Congress Days

Day	Track	Time	Session	Attendance
Day 1	Track 1	09:20 - 11:00	Pitfalls during US guided blocks: All the structures you should not miss. All steps clear?	415
Day 2	Track 1	09:20 - 11:00	Update on thoracic blocks	344
Day 1	Track 1	11:50 - 12:50	RA & antithrombotic agents: A literature update	324
Day 1	Track 1	16:00 - 17:00	RA and the difficult patient	277
Day 2	Track 1	11:50 - 12:50	Point-of-care ultrasound (POCUS): Unnecessary gadgetry or evidence-based medicine?	256
Day 1	Track 1	14:10 - 15:10	The OB factor! Solving problems in the OB ward!	249
Day 1	Track 2	10:00 - 11:00	New blocks in RA practice: What is the evidence?	243
Day 1	Track 2	14:10 - 15:10	Controversies in RA: Safety first!	229
Day 1	Track 2	11:10 - 11:40	RA in the obese patient: The role of spinal US in a challenging task	223
Day 2	Track 1	14:10 - 15:10	Rethinking subarachnoid block in ambulatory surgery	223
Day 1	Track 1	15:20 - 15:50	Infiltration or blocks for knee surgery?	218

Engraved in ESRA's DNA is the appreciation for the discussion of research and sharing of clinical experience (case reports). The most viewed e-posters were: Lumpectomy under interpectoral block and pecto-intercostal fascial block (121 views), Ultrasound guided costoclavicular brachial plexus block for proximal humerus fracture with pneumothorax in an elderly patient – a case report (54 views), Comparing the efficacy of pericapsular nerve group block (PENG) block versus supra-inguinal fascia iliaca block (FIB) in hip arthroplasty (45 views), 185 Neuraxial drug administration errors from 40 countries – practical issues and human factors (44 views) and Low-dose, opioid-free subarachnoid block and US-guided suprainguinal FICB as an anaesthetic analgesic technique in patients with a symptomatic, mild to moderate aortic stenosis undergoing hip fracture surgery (31 views).
The award-winning abstracts of this 2021 ESRA Virtual Congress are presented

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- Lumpectomy under interpectoral and pecto-intercostal fascial block (121 views)
- Ultrasound guided costoclavicular brachial plexus block for proximal humerus fracture with pneumothorax in an elderly patient – a case report (54 views),
- Comparing the efficacy of pericapsular nerve group block (PENG) block versus supra-inguinal fascia iliaca block (FIB) in hip arthroplasty (45 views),
- 185 Neuraxial drug administration errors from 40 countries – practical issues and human factors (44 views)
- Low-dose, opioid-free subarachnoid block and US-guided suprainguinal FICB as an anaesthetic analgesic technique in patients with a symptomatic, mild to moderate aortic stenosis undergoing hip fracture surgery (31 views).
- During the virtual ESRA congress, abstract committee had a difficult task to choose three best abstracts for regional anaesthesia and chronic pain categories. We have invited the authors to present their work in their own words for our readers. We would like to sincerely congratulate all winners for their great achievement.

Regional anaesthesia

1st Prize for regional anaesthesia
Manabu Yoshimura (Ube, Japan): COMPARISON OF PERIPHERAL NERVE BLOCK WITH GENERAL ANESTHESIA AND GENERAL ANESTHESIA ALONE IN TERMS OF POSTOPERATIVE DELIRIUM AND COMPLICATIONS USING A NATIONWIDE DATABASE

2nd Prize for regional anaesthesia
Ellen Veef (Leuven, Belgium): PROSPECT GUIDELINE FOR ELECTIVE CAESAREAN SECTION: UPDATED SYSTEMATIC REVIEW AND PROCEDURE-SPECIFIC POSTOPERATIVE PAIN MANAGEMENT RECOMMENDATIONS

The pain after caesarean section is often underestimated and undertreated, nevertheless it may have negative impact on maternal recovery and wellbeing, but also on the mother-child bonding and the breastfeeding. Several new techniques have been developed and the attention has shifted towards reduced opioid consumption and enhanced recovery after surgery. A total of 145 studies were included (126 RCTs + 19 systematic reviews and meta-analyses). PROSPECT working group provided recommendations based on recent literature on pain after elective caesarean section under neuraxial anesthesia, which consists of multimodal analgesia (paracetamol, NSAID's, dexamethasone) and intrathecal morphine. Peripheral nerve blocks can be used when neuraxial anaesthesia is not used.

3rd Prize for regional anaesthesia
Freideriki Sifaki (Athens, Greece): EFFECTIVENESS OF ULTRASOUND – GUIDED BILATERAL ERECTOR SPINAE PLANE BLOCK IN LAPAROSCOPIC CHOLECYSTECTOMIES. A RANDOMIZED, CONTROLLED, DOUBLE BLIND, PROSPECTIVE TRIAL

Authors demonstrated, that patients undergoing laparoscopic cholecystectomy who received bilateral ESP blocks with ropivacaine or ropivacaine+dexmedetomidine had lower opioid consumption at 24 hours, lower NRS pain scores and shorter time to mobilisation compared with the control group who received saline to ESP blocks. Patiets with ESP blocks had also higher satisfaction scores than control group. Addition of dexmedetomidine to ropivacaine has not resulted in any difference in above variables compared with ropivacaine alone.

Chronic pain

1st Prize for chronic pain:
Caner Genç (Samsun, Turkey): EFFECTS OF ULTRASOUND-GUIDED ERECTOR SPINAE PLANE BLOCK AND PECTORALIS NERVE BLOCK ON POSTOPERATIVE ACUTE AND CHRONIC PAIN IN PATIENTS WHO UNDERWENT BREAST CANCER SURGERY

2nd Prize for chronic pain
Raquel Vela (MADRID, Spain): RELATIONSHIP BETWEEN COMORBIDITIES IN PATIENTS WITH CHRONIC LOW BACK PAIN UNDERGOING INTERVENTIONAL PAIN MANAGEMENT TECHNIQUES, AND PATIENT SATISFACTION AND CLINICAL RESPONSE

Patients with failed back surgery syndrome and neuropathic pain have lower response rate and lower satisfaction to commonly performed interventional pain techniques – lumbar interlaminar epidural, lumbar caudal epidural and facet joint infiltration. Patients with these clinical features may be resistant to the interventional techniques offered or they may require different or more specific techniques than the ones performed.

3rd Prize for chronic pain
Ana Amorim (Funchal, Portugal): KNEE PAIN: EXPERIMENTAL RADIOFREQUENCY

Social Media

In terms of visibility on social media, #ESRA2021 achieved about 7,574M impressions. The top 5 influencers were ESRA, Amit Pawa, Steve Coppens, Ed Mariano and Clara Lobo

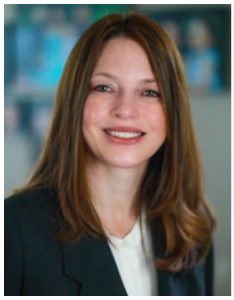
Some statistics figures on Twitter with the top 10 influencers: @ESRA_Society, @amit_pawa, @Steve_Coppens, @EMARIANOMD, @claralexlobo, @RegionalAnaesUK, @OTJOnline, @ajrmacfarlane, @PeterMerjavy, @cdrrogers

Both congress days ended with a Wrap Up session where, in a calm environment, the most important messages of the day of each track were shared and discussed.

To view or review your favorite sessions of The ESRA Virtual Congress 2021 you can access the platform for 1 year, here.

TikTok and its role in regional anaesthesia education

Melody Herman (Regional & Acute Pain Anesthesiologist, Atrium Health's Carolinas Medical Center - Charlotte, NC, USA) @anesthesiadocmd



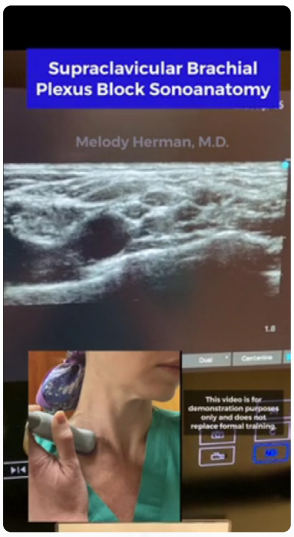
> " These micro lessons can help viewers grasp key concepts, self-serve gaps in their understanding, and revisit videos numerous times until a block is mastered. "

In the era of fascial plane blocks and handheld ultrasounds, the number of new nerve blocks and patients receiving blocks continues to expand. The TikTok format of bite-sized instructional videos is an effective education tool for both regional anaesthesia novices and experts.

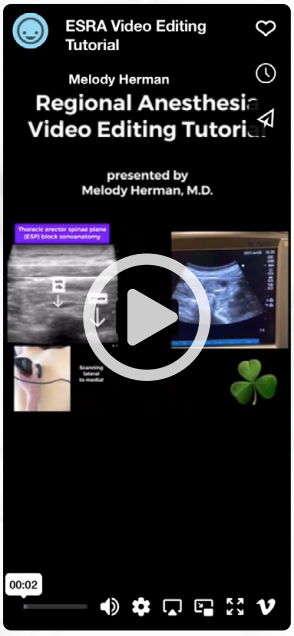
To be successful, first decide your audience. Twitter is a great platform for regional anaesthesia how-to videos. Keep the video concise and to the point, ideally 15 to 45 seconds duration. The beauty of this short duration is that it is a quick introduction or refresher to an unfamiliar block. Unlike Twitter, most TikTok audiences are not interested in learning how to do a block. However, they are engaged with interesting regional anesthesia content that is easy to understand.

The easiest way to create these videos is through a video editing app. A good approach is to start with a voiceover to the video, then edit the video to match the voiceover. Text, clip art, animation, and background music can give life to content that is ordinarily mundane. Verify before posting that what you have created is correct. Anatomy that is mislabeled or incorrect facts are quickly identified by regional anaesthesia commentators on Twitter. Although it can be tempting to give a more thorough review of the block typical of YouTube instructional videos, for a TikTok-style presentation it is best to stay under 1 minute duration. TikTok at times is a forum for bullying, even with regional anaesthesia content! Before posting on any social media platform, be mindful of how much of your identity you are comfortable sharing publicly.

The entirety of regional anaesthesia education cannot easily be condensed into the time constraints of a TikTok-style video. However, these micro lessons can help viewers grasp key concepts, self-serve gaps in their understanding, and revisit videos numerous times until a block is mastered. "Nerve block TikToks" match the fast-paced innovation in regional anaesthesia by allowing us to quickly refresh our knowledge, appreciate the sonoanatomy of differing ultrasound scans, and view the techniques of our regional anaesthesia colleagues worldwide.



Screenshot of a TikTok video made by Melody Herman



Postoperative pain management after total hip arthroplasty: The updated guideline from PROSPECT


Roseanne Wilkinson (Medical Writer, Medical Writing Ltd - Cambridge, UK)

"Clinicians have needed an up-to-date guideline providing an evidence-based approach to pain management for elective THA."

The PROSPECT initiative, led by an expert working group of anaesthesiologists and surgeons, provides healthcare professionals with practical recommendations for postoperative pain management in common surgical procedures.

Total hip arthroplasty (THA) is frequently performed and associated with significant postoperative pain. Patients require effective analgesia with minimal side effects to enable early postoperative mobility and functional recovery (*Joshi 2019*). However, there is wide variability in the peri-operative anaesthetic and analgesic regimens used.

Clinicians have needed an up-to-date guideline providing an evidence-based approach to pain management for elective THA. The PROSPECT working group has delivered with this recent publication, which was widely shared on social media (attention score in the top 5% of all research outputs on *Altmetric*):

"PROSPECT guideline for total hip arthroplasty: a systematic review and procedure-specific postoperative pain management recommendations" (*Anger M, et al. Anaesthesia 2021; 76: 1082–1097*).

The guideline was developed based on a systematic literature review that focused on postoperative pain outcomes. Using PROSPECT's unique approach, the working group assessed the effects of analgesic interventions in reference to the use of basic analgesics (paracetamol and NSAIDs or COX-2 selective inhibitors) and the balance of risks and benefits in the context of multimodal, non-opioid analgesic strategies and modern peri-operative care pathways.

The overall recommendations for elective THA are shown in Table 1 and are also available on the *PROSPECT website*.

Table 1. Overall recommendations for peri-operative pain management in patients undergoing total hip arthroplasty	
Pre-operative and intra-operative interventions	• Pre-operative exercise and education (Grade A) • General or spinal anaesthesia (Grade A) • Paracetamol (Grade A) • Non-steroidal anti-inflammatory drugs or cyclo-oxygenase-2-selective inhibitors (Grade A) • Dexamethasone 8–10 mg intravenously (Grade A) • Single shot fascia iliaca block or local infiltration analgesia (Grade D) • If the patient has received spinal anaesthesia for the surgery, intrathecal morphine 0.1 mg could be considered (Grade D)
Postoperative interventions	• Paracetamol (Grade A) • Non-steroidal anti-inflammatory drugs or cyclo-oxygenase-2-selective inhibitors (Grade A) • Opioid for rescue (Grade D)

The evidence, recommendations and methodology for THA and all the PROSPECT reviews (currently 19 surgical procedures) can be found on the website, *esraeurope.org/prospect*, together with links to all PROSPECT publications (most are open access).

New PROSPECT reviews and updates are underway. Those nearly finalised include sternotomy, hip fracture, total knee arthroplasty (update), video-assisted thoracoscopic surgery, laparoscopic colectomy, open abdominal hysterectomy and prostatectomy.

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

Results of the ESRA-Grunenthal Survey on Degenerative Disc Disease

Özgür Sancak, MD. PhD. (Grunenthal VP Global Medical Affairs)

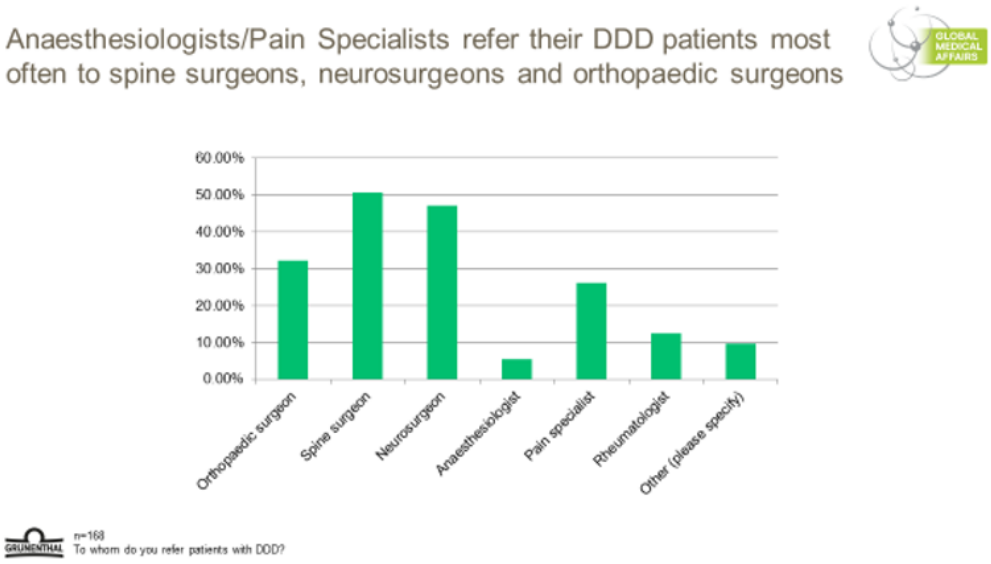
Low back pain (LBP) is the leading cause of disability worldwide [1]. In 2015, the global point prevalence of activity-limiting low back pain was 7.3%, responsible for around 60.1 million years lived with disability in 2015 – an increase of 54% since 1990 [1]. In 80–90% of cases, LBP is self-limited (lasting <6 weeks with a favourable prognosis), but approximately 5–10% of patients with LBP develop chronic LBP (symptoms lasting >3 months) [2]. Degenerative disc disease (DDD) is the most common etiology of cLBP in adults [3-5]. The current treatment options for cLBP associated with DDD include conservative nonpharmacological and pharmacological treatments as well as interventional and surgical treatments [2, 6]. General practitioners, physiotherapists, neurosurgeons and orthopaedic surgeons play a role in the diagnosis and management of these patients, but little is known about the role of the anaesthesiologists and pain specialists.

ESRA and Grunenthal developed an online survey in order to:

- better understand the role of anaesthesiologists / pain specialists in diagnosis and treatment of cLBP associated with DDD
- gain insights into the disease and its associated signs and symptoms
- understand the tools health care professionals utilise for differential diagnosis, and
- understand DDD patient journey.
- The survey was launched on the 19th of September 2020 during the ESRA & ASRA International e-Congress. Data collection concluded on the 6th November with the participation of 363 respondents across Europe, 96% of which were anaesthesiologists and/or pain specialists.

Over 74% of the respondents are actively involved in the diagnosis and/or management of cLBP associated with DDD, which highlight the substantial role anaesthesiologists and pain specialists undertake.

Anaesthesiologists/Pain Specialists refer their DDD patients most often to spine surgeons, neurosurgeons and orthopaedic surgeons.

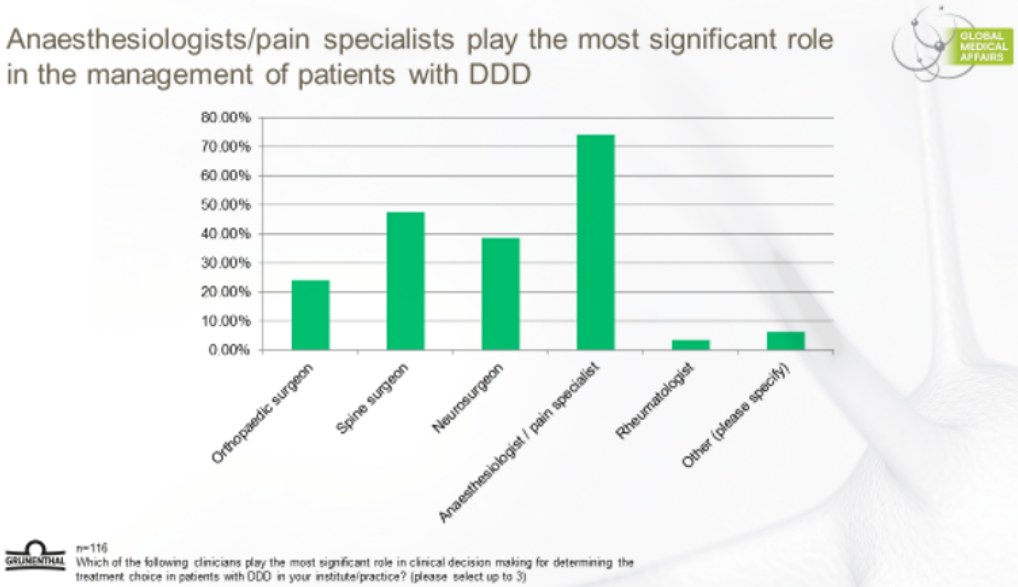


According to the respondents, most bothersome signs/symptoms which drive patients to seek medical advice are worsening back pain and the impact back pain has on their daily functioning, 57% and 63% respectively.

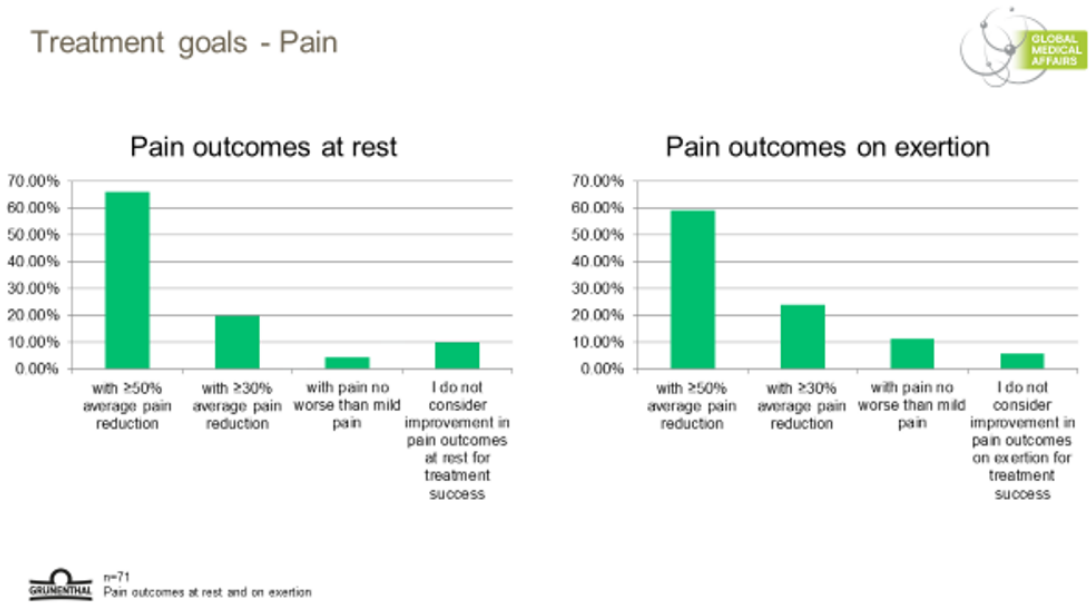
Signs and symptoms particularly associated with DDD are the location and quality of back pain as well as its functional impact, with 53%, 43% and 44% respectively.

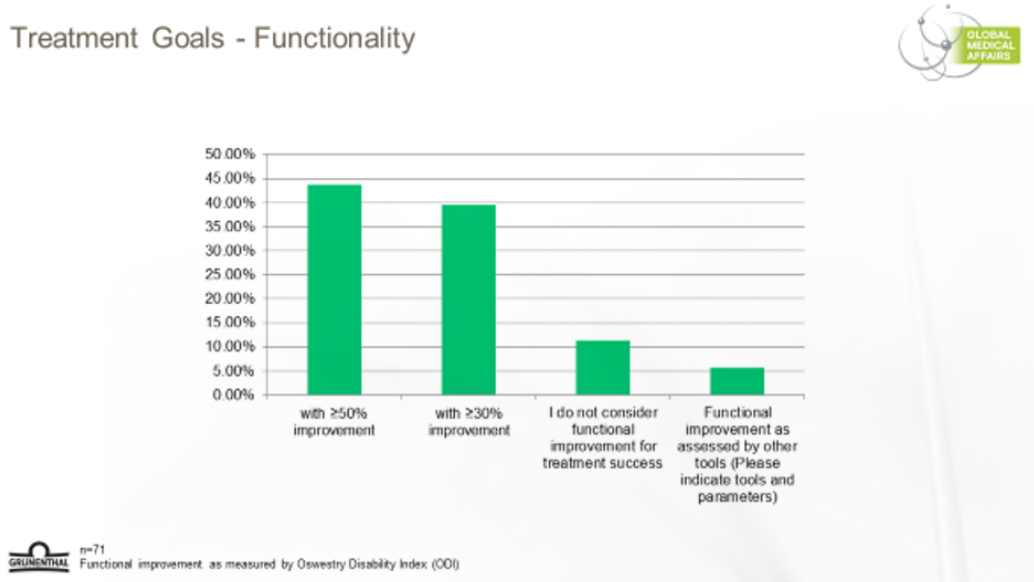
Magnetic resonance imaging is the preferred imaging modality used for the differential diagnosis (90%), followed by plain x-ray (27%) and CT (21%). Discography is needed / employed in up to 19% of cases. According to respondents, approximately 1/3 of the patients have a single level of symptomatic degeneration, 1/3 of the patients have two, and the others have multiple levels.

Anaesthesiologists and/or pain specialists play the most significant role in the management of patients with DDD, followed by spine surgeons, orthopaedic surgeons and neurosurgeons.

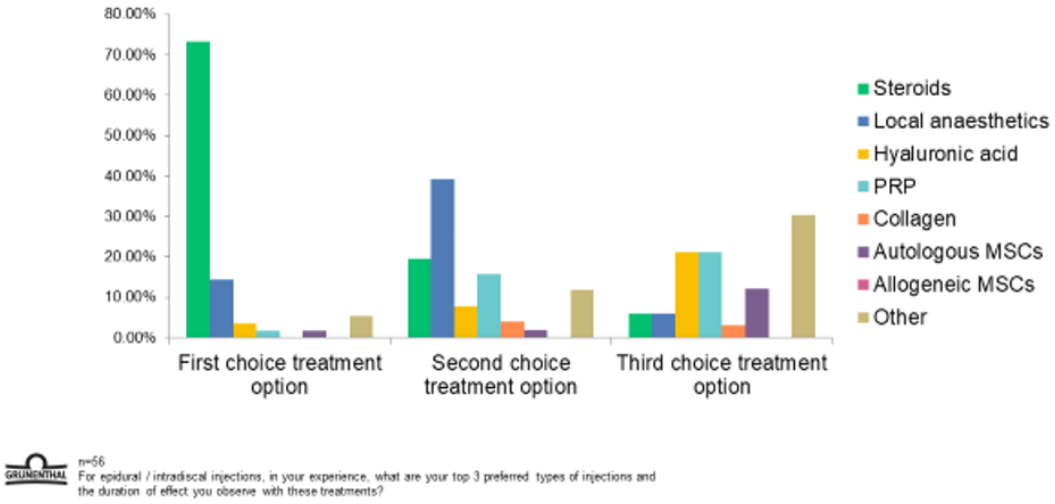


Treatment goals of the respondents for their patients with cLBP associated with DDD are to provide substantial pain relief at rest and on exertion, as well as to provide functional improvement.

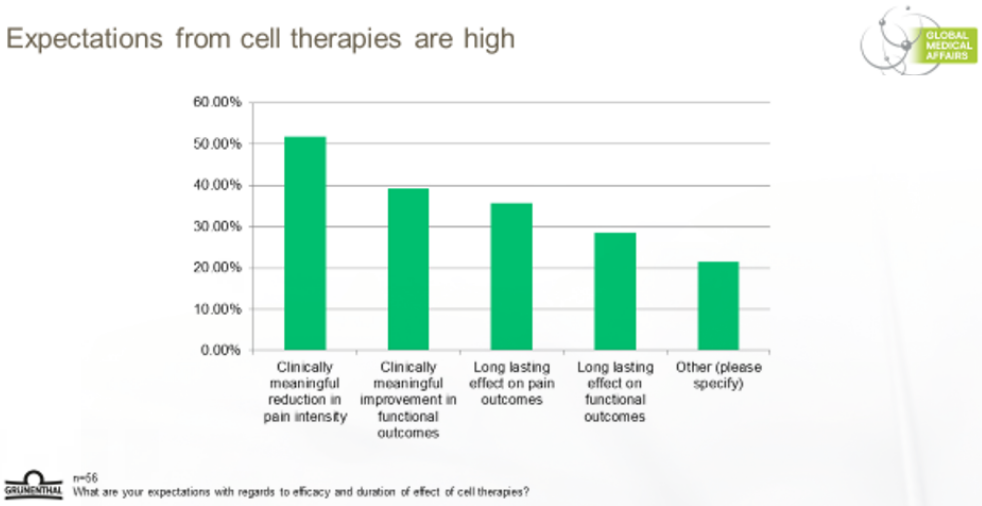




Epidural and/or intradiscal injections are commonly administered in patients with cLBP associated with DDD. Steroids and local anaesthetics are the most commonly employed as first or second line treatment.



The majority of the respondents have no experience with cell therapies in the treatment of DDD (86%), but expect that such therapies may provide long lasting, clinically meaningful reduction in pain intensity and improvements in functional outcomes.



In summary:

- Anaesthesiologists and/or pain specialists seem to play an important role in the management of patients with DDD
- Limited resources/guidelines force clinical decision making based on personal experiences rather than evidence based medicine
- There is a need for continued medical education also including cell therapies
- DDD patients are difficult to diagnose, difficult to manage and difficult to treat
- Limited treatment options
- 30% surgical candidates
- 40% of those decline surgery

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What's new inside ESRA

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

"ESRA Major Officers and Board are very excited with this new internal organization and have the best expectations from all the members involved."

Change is part of life! And it is with new blood that societies renew and evolve. Nevertheless, it is also true that we should not change a winning team!

As the Secretary General of ESRA I am happy to present our members some of the changes and "non-changes" on ESRA People, since September 2021 and for the next 3 years.

This September, ESRA held elections in its social frameworks and added to the structure of committees with the creation of the ESRA International Committee.

My sincere congratulations to Eleni Moka (Greece) for her re-election as ESRA Treasurer for the second term (2021-2024). I wish to pay tribute and a sincere recognition to her excellent job, as the leader of our financial affairs.
ESRA board kept Enrico Barbara (Italy) for his second term (2021-2024). The departure of José Aguirre (Switzerland) from the ESRA board was filled with the arrival of Eric Albrecht (Switzerland) who will start his first term (2021-2024). Congratulations for both members of ESRA Board.

The Committees are important structures of ESRA, maintaining the spirit and creativity behind the scenes. Some Chairs finished their first term and accepted the invitation from the ESRA Board to continue for another term: the Education and ESRA day committees remained unchanged for another 3 years, with Chairs Marc Van de Velde (Belgium) and Sebastien Bloc (France), respectively. As for the e-ESRA Committee, Luc Mercadal (France) will have José Aguirre (Switzerland) as co-Chair in the next term.
José Aguirre (Switzerland) ended his term as Chair of the EDRA Committee and was succeeded by Morné Wolmarans (UK). Peter Merjavy (UK) stepped in as the new Vice-Chair for EDRA Part 2 and Andrea Saporito (Switzerland) and Balaji Packianathaswamy (UK) as a member and co-opted member of the EDRA board, respectively. Felicitations to all of the new members of EDRA board.

The number of non-European members has been increasing in recent years, accounting for about 15% of ESRA members. In recognition, the ESRA board decided to acknowledge and welcome members from other non-European communities, giving them a voice inside the society, through the ESRA International Committee, led by Alain Delbos (France), Past President, and Patrick Narchi (France), Ambassador Program Chair, as Chairs. Communities with more than 30 members are eligible to elect a representative to take a seat at this Committee, for a period of 3 years (renewable once). In September 2021, non-European communities with more than 30 members are: India (157), United States of America (100), Australia (96), Japan (83) and South Africa (48).

ESRA Major Officers and Board are very excited with this new internal organization and have the best expectations from all the members involved, working for the benefit of the ESRA and its members, promoting education and research in peri-operative medicine, regional anaesthesia, chronic therapy and PoCUS.
To see who's who inside ESRA follow the link: *https://esraeurope.org/team/*

Introduction of “EDRA Approved” criteria for workshops


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


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

“ Therefore, from October 2021 ESRA has published updated and much more detailed criteria for workshops required for EDRA exam. There is still a need to attend at least one ESRA official WS, but the total number of workshops has changed to a points system. ”

European Diploma in Regional Anaesthesia (EDRA) has continued to gain popularity among anaesthesiologists across the world since its introduction in 2006. There are some important prerequisites the candidates need to submit as part of their application to take the exam. Providing the evidence of attendance for at least 3 RA workshops is essential in order to ensure that the candidates are appropriately prepared for the high standards required for success in the exam.

From the 3 workshops, at least one must be an official ESRA workshop (WS), at least one must be cadaveric, and one can be ultrasound scanning WS. THE required ESRA workshop does not have to be a cadaveric WS and similarly the cadaveric WS does not need to be an ESRA workshop.

ESRA obviously knows their faculty for their own workshops, but it has become more and more of a concern that the quality of workshops available to EDRA candidates may be of variable quality. Some workshops may also have a very high number of candidates per 1 workshop station, which limits the scanning and learning opportunities for candidates. There would also be a huge discrepancy in the number of hours spent learning at these workshops, for example some candidates may spend 28 hours in workshops and others only 10 hours, but both would still fulfil the current EDRA exam criteria.

Therefore, from October 2021 ESRA has published updated and much more detailed criteria for workshops required for EDRA exam. There is still a need to attend at least one ESRA official WS, but the total number of workshops has changed to a points system. Please be aware, that candidates need to submit the evidence of the collected points from all required workshops only for EDRA Part 2 exam. That means, the candidate can apply for EDRA Part 1 (written) exam without completing all necessary workshop points.

In order to apply for EDRA Part 2 exam, candidate must present at least 20 points from the EDRA approved workshops, whilst providing the evidence for:

- At least 6 points hands-on cadaveric points (HO-CP)
- At least 10 points hands-on ultrasound points (HO-UP)

It needs to be highlighted, that all 20 points cannot be obtained in one workshop.

By offering the general criteria for organisers of regional anaesthesia workshops in European countries, ESRA wishes to expand the pool of approved high-quality workshops in more countries and allow the candidates to be able to choose which workshop they would like to attend according to their needs in terms of geographical proximity, language or workshop points offered / required for the EDRA exam. An approved list of workshops according to the countries will soon be created as well as list of workshop categories (cadaveric, ultrasound, official ESRA) giving full flexibility to the candidates to make the right choice.

The EDRA board realises that new criteria may seem daunting and difficult to implement for candidates and course organisers. Therefore, there will be an initial grace period where workshops attended before June 2022 will still be valid for EDRA exam criteria. The EDRA board will apply some flexibility until the new criteria has been fully established, with the expectation that workshops from July 2022 apply for EDRA points and " EDRA Approved" status.

To make it easier for our readers and workshop directors who would like to apply for "EDRA Approved" status for their workshop the following workshop points are highlighted in different colour:

Hands – on cadaveric points (HO-CP)

Other cadaveric points (CP)

Hands – on ultrasound points (HO-UP)

Other ultrasound points (UP)

Cadaveric points – CP

- 1 point awarded for every 1 hour of direct hands-on practice with cadavers (dissected specimens, soft embalmed or fresh cadavers).
  Example: 6 hours of cadaveric hands-on practice = 6 HO-CP
- 0.5 point awarded for every hour of anatomy related lecture
  Example: 4 hours of cadaveric lectures = 2 CP
- Lectures which are not related to applied anatomy will not be counted

Ultrasound points – UP

- 1 point awarded for every 1 hour of direct hands-on ultrasound scanning of live model / needling on phantom
  Example: 6 hours of ultrasound scanning = 6 HO-UP
- 0.5 points awarded for every 1 hour of sono-anatomy related lecture / demo
  Example: 4 hours of lectures/demo = 2 UP
- Lectures / demos which are not related to ultrasound and sono-anatomy will not be counted

Rounding the total time for points

- Full hours will be counted without change
- 0-29 min will be rounded to previous hour
- 30-59 min will be rounded to next hour

Example 1: 5 hours and 20 minutes = 5 hours
Example 2: 5 hours and 45 minutes = 6 hours

Final point count

HO-CP Hands – on cadaveric points are displayed on workshop certificate separately
HO-UP Hands – on ultrasound points are displayed on workshop certificate separately
OP Other points are calculated by adding CP (cadaveric points) and UP (ultrasound points) together. Other points represent all cadaveric or ultrasound "non hands – on" points awarded for the workshop

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***Certain* minimum standards for *"EDRA Approved"* workshops are necessary to maintain high quality teaching and fulfil the learning needs for our candidates**

- Cadaveric and/or ultrasound points must be successfully submitted by WS director and approved by ESRA
- At least 50% of the workshop faculty members must be ESRA members (or other EDRA approved partner organisation – e.g. ASRA, AOSRA, LASRA)
- Workshop director must be EDRA diplomate and/or have academic background and/or substantive teaching experience in the field of regional anaesthesia and acute pain management
- Maximum number of participants per group is 8 for ultrasound and for cadaveric workshops to allow appropriate hands-on experience
- EDRA Board reserves the right to send EDRA Board member, EDRA examiner or other EDRA Board approved person to personally inspect the course at the expenses of workshop organiser.

Recommendations for EDRA Approved workshop (WS) application process:

- Submit the programme of the WS to the national organisation for CME/CPD* approval
- After granted CME/CPD, submit both the programme and CME/CPD approval to ESRA for assessment by email and specify in the table below the hours of anatomy/ Sono-anatomy lectures as well as cadaveric / ultrasound hands-on practice
- WS director should allow 2 calendar months for EDRA Board/COR response of their WS assessment
- *EDRA Approved* status is issued to organiser of the workshop for the duration of up to 3 calendar years (including the year of registration). After this period, WS director must reapply for EDRA Approved status again.
- Organisers must submit candidates feedback within 30 days after the workshop in order to keep the EDRA Approved status for next calendar year. ESRA feedback templates are downloadable for Cadaveric and Ultrasound Workshops.
- Workshop must comply with *EDRA Approved* minimum standards
- When the programme of the workshop changes dramatically, which will result in change of WS points, organiser must submit a new application.
- WS director can use *"EDRA Approved"* logo on all advertising materials related to WS, certificate as well as on the screen during the WS.

*CME – continuous medical education
*CPD – continuous professional development

Example of workshop

(Belfast 2019)

Day 1			Time
08:00 – 09:00	**Registration & Introduction**		
09:00 – 09:30	**Lecture**		
	Applied anatomy for Upper Limb Blocks		0:30
09:30 – 09:45	**Live demo 1** – Upper Limb Blocks		0:15
09:45 – 10:15	**Lecture**		
	Applied anatomy for Lower Limb blocks		0:30
10:15 – 10:30	**Live demo 2** - Lower Limb Blocks		0:15
10:30 – 11:00	Coffee break		
11:00 – 11:30	**Lecture**		
	Applied anatomy for spinal & paraspinal blocks		0:30
11:30 – 11:45	**Live Demo 3** - Neuraxial, PVB		0:15
11:45 – 12:15	**Lecture**		
	Best for chest – Applied anatomy for Trunk blocks		0:30
12:15 – 12:30	**Live Demo 4** - Trunk blocks		0:15
12:30 – 13:30	Lunch		
13:30 – 15:30	**U/S live workshop**		2:00
15:30 – 16:00	Coffee break		
16:00 – 18:00	**U/S live workshop**		2:00

Day 2			
07:30 – 08:00	Faculty arrival/set up room for FFC (fresh frozen cadavers)		
08:00 – 08:15	**Introduction**/orientation to Dissection Room / day rules etc		
08:15 – 09:00	**FFC WS 1**	Parasacral, subgluteal & popliteal sciatic	0:45
09:00 – 09:45	**FFC WS 2**	Paravertebral, MTP, ESP (+catheter)	0:45
09:45 – 10:15	Coffee/Tea		
10:15 – 11:00	**FFC WS 3**	QLB 1,2,3 + Shamrock LPB	0:45
11:00 – 11:45	**FFC WS 4**	PECS, SPB, Rectus Sheath	0:45
12:00 – 13:00	Lunch		
13:00 – 13:45	**FFC WS 5**	Femoral, LCNT, Obtur, SIFIB	0:45
13:45 – 14:30	**FFC WS 6**	ACB/FTB, ankle	0:45
14:30 – 15:00	Coffee/Tea		
15:00 – 15:45	**FFC WS 7**	Interscalene, Supraclavicular, Cervical Plexus	0:45
15:45 – 16:30	**FFC WS 8**	Infraclavicular (costoclavicular), Axillary	0:45
16:30 - 16:45	Coffee/Tea		
16:45 – 17:45	**Free session with 4 Fresh Cadavers** stations		1:00
18:00	Final remarks		
18:30	Faculty debrief		

	hours	points	CP	UP
Anatomy lectures	2:00	1	1	-
Cadaveric hands-on	**7:00**	**7**	7	-
Ultrasound lectures/demo	1:00	0.5	-	0.5
Ultrasound hands-on	**4:00**	**4**	-	4
Cadaveric points (CP) total	**7 HO-CP**		1 other CP	
Ultrasound points (UP) total	**4 HO-UP**		0.5 other UP **(1.5 OP)**	

ESRA annual congress 2022


Eleni Moka (ESRA Treasurer, Creta Interclinic Hospital, HHG - Heraklion-Crete, Greece) @mokaeleni


Alain Delbos (ESRA Past President; Medipole Garonne, France) @alaindelbos

> " As the world emerges from COVID-19, we are excited to announce our plan to provide a safe, strong, inspiring, innovative, face-to-face meeting, in the magnificent city of Thessaloniki."

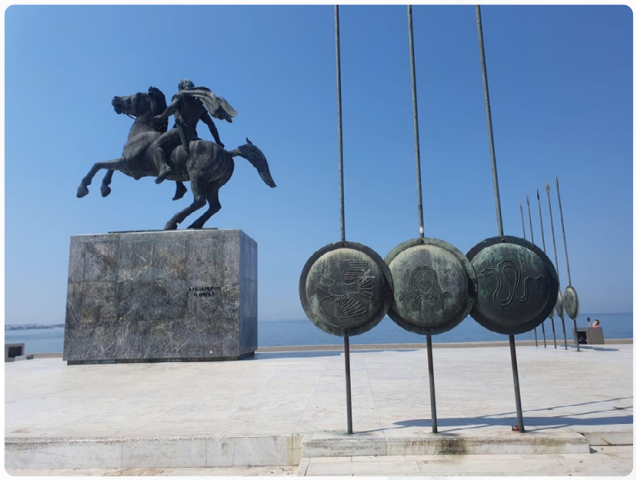
Dear Colleagues and Friends,

On behalf of the Scientific Committee and the 2022 Local Organizing Committee (LOC 2022) of the European Society of Regional Anaesthesia and Pain Therapy (ESRA), we have the pleasure and privilege to invite and welcome you to Thessaloniki – Greece, for the 39th ESRA Annual Congress, taking place in June 22 – 25, 2022.

We were so saddened when we had to postpone our presential Annual Congress twice, in 2020 and 2021, but public health was and remains our priority. Instead, last September we organized a successful fully virtual event, by pivoting the scientific program into a totally new digital format, which was challenging but ensured that people from all around the world could meet safely online.

As the world emerges from COVID-19, we are excited to announce our plan to provide a safe, strong, inspiring, innovative, face-to-face meeting, in the magnificent city of Thessaloniki, along the seaside, and we are highly optimistic that we will be able to safely meet again in person, after prolonged pandemic-related restrictions.

The ESRA Annual Congress is currently considered as one of the largest, world-class platforms for clinicians and scientists, within the rapidly evolving Regional Anaesthesia (RA), Perioperative Care and Chronic Pain Therapy Communities. It offers multiple possibilities for networking with more than 2.500 healthcare professionals from all over the world, as well as the opportunity to promote interprofessionalism, share cutting-edge research and renew clinical management skills. In this context, and following the well-known ESRA tradition, we made an intentional effort to redesign an exceptionally diverse and high-standards scientific program, that would be of interest to both young and experienced RA and Chronic Pain enthusiasts.



«We are going through an exciting time for both RA and Pain Therapy, with both subspecialties still growing and evolving in a challenging healthcare environment.»

We are going through an exciting time for both RA and Pain Therapy, with both subspecialties still growing and evolving in a challenging healthcare environment. The chosen theme of the 39th ESRA Annual Congress is "Shaping the Future of RA, Perioperative Care & Pain Therapy", reflecting our intentions to provide a perspective on how RA, Perioperative Care and Pain Medicine practices have stood the test of time and coronavirus pandemic, along with highlighting exciting new innovative techniques or therapies, that could be proven as beneficial for our patients in the future.

Among all program elements, one needs to underline state-of-the-art presentations on our fields of interest, as well as key-note lectures on new insights, ranging from basic and translational science to clinical research and therapeutic interventions. Contemporary developments and recent clinical findings will be presented and discussed, and the latest related evidence will be debated, on areas such as application and daily practice of Regional Anaesthesia/Analgesia, Patients' Perioperative Care, POCUS, as well as Acute and Chronic Pain Management aspects.

The congress format will encourage interactivity, framed by your input, engagement and proaction. We have created a high-quality, world-renowned, experts-filled scientific program, modified, and focused on enforcing networking between faculty and the audience, which is considered of utmost importance. A variety of interactive sessions have been planned to be expanded in 12 parallel halls, consisting of Networking Sessions, Symposia, Experts' Panel Discussions, Instructional Refreshing your Knowledge & Ask the Expert Lectures, 2nd Opinion Discussions with concluding Consensus, Luncheon and Tips & Tricks Sessions, Problem-Based Learning & Complex Cases Discussions, as well as PRO-CON Debates. Interestingly, voting and ask the speaker features will be available via the congress app, further enforcing interactivity and audience participation. Special Hands-On Clinical and Cadaver Workshops will also be organized, dedicated to one-by-one, in-person training by experts, in small groups of participants, whereas Live Demonstration of Interventional Techniques Application on Patients for Chronic Pain Management will take place inside the Operating Room of Local Hospital Facilities. In addition to the main stage of the congress, the new concept of 360o Open Simulation Courses will be another striking point, that will feature faculty and delegates with "true" practice perspectives, whereas the exhibition area set up will provide more time for interactivity with our valued sponsors and exhibitors.

«There is nothing to beat social contact and physical networking.»

Further, the 2022 ESRA Annual Congress will deliver multiple exciting learning opportunities specifically designed for Residents, Trainees and Fellows, including but not limited to Free Papers and E-Posters Sessions. All are cordially invited to submit their work for inclusion in the ESRA Resident Best Free Paper and Best Abstract Award competitions. Last but not least, written and oral exams of the well-established EDRA and EDPM Diplomas will take place in parallel with the congress main scientific program.

Finally, a variety of social events will be organized, including the well-known opening ceremony and networking reception in the heart of the city, at the Thessaloniki Concert Hall, the ever-popular Trainees & Diplomates reception, by the sea, along with some local and traditional flavour, the famous ESRA Fun Run, and the ESRA Annual Networking Dinner at an exceptional spot across the seaside.

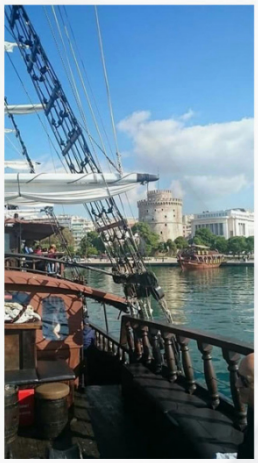
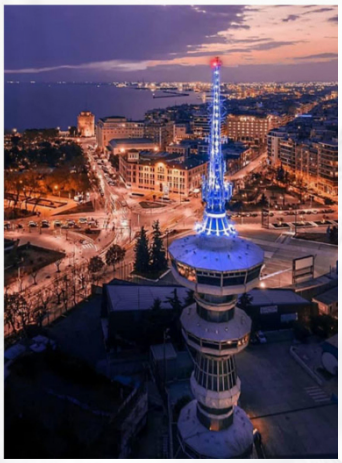
We cannot think of any better location for next June to offer this substantive assortment of new and traditional educational offerings on RA, Perioperative Care and Chronic Pain Therapy, than the vibrant city of Thessaloniki in Greece, internationally renowned for its history, culture, entertainment, nightlife and fine dining. We are convinced that by next summer hygienic conditions will allow the presence of our members and community. There is nothing to beat social contact and physical networking; therefore we are looking forward to meeting you again in person and sharing the highest quality scientific contributions, as well as the professional and social exchanges this magnificent city will foster during the 39th ESRA Annual Congress in 2022.

Looking at a brighter future, we are counting on your support, enthusiasm and interactive participation, to share with you the occasion of this ESRA Congress, in a friendly ambience, for another memorable experience and for celebrating the 40th anniversary since the society establishment.

Website link: *https://esra2022.com*





ESAIC-ESRA guideline

Thomas Volk (ESRA Past-President, Germany) @ThomasVolk16

In early 2019 ESAIC approached ESRA to develop a new guideline on anticoagulants and regional anesthesia. The group was headed by Sibylle Kietaibl and on ESRAs side Clara Lobo, Alan MacFarlane, Thomas Volk and Morné Wolmarans volunteered to work on this project. It has been decided to use a modified PICO method mixed with clinical questions to determine pausing times for anticoagulants and platelet inhibitors. The drugs were restricted to vitamin K antagonists, direct oral antagonists, low molecular weight heparins and unfractionated heparin, Aspirin and P2Y12 inhibitors. The group screened 65.577 publications. As the incidence of an epidural hematoma related to neuraxial blocks or severe bleeding complications after a peripheral block is so low, there were no randomized trials to give a definite answer. The group consequently used simplified pharmacokinetic models and a consensus procedure on 40 grouped recommendations. 23 of these were strong (>90% agreement). Compared to existing national European guidelines there still might be differences. However, as this project represents a European compromise it may hopefully be an aide for national decisions. The whole publication will soon be available online in the European Journal of Anesthesiology.