

SP45 DOCUMENTATION IN REGIONAL ANAESTHESIA

G Crowe, B Atterton, Moran EM Louise. *Letterkenny University Hospital, Letterkenny, Ireland*

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Documentation is of paramount importance in all aspects of medical practice, indeed many international governing medical bodies place accurate record keeping as one of the fundamental requirements for good clinical care.^{1 2} Accurate and concise documentation is not only a record of patient management, but also facilitates continuity of care, education and research, and has an important medicolegal role. Regional anaesthesia forms an integral part of modern anesthetic practice and with increasing evidence of benefits for acute and chronic pain management it is becoming ever more popular. Despite this rising popularity, there is a lack of international consensus regarding the minimum standards for its documentation. By contrast, there exist extensive international guidelines on documentation in general anaesthesia.³

Limited work has been done in this area previously at a national level in Ireland and the US, including the formation of a proposed standardized block note.^{4 5} More recently an international expert panel, jointly supported by ESRA and ASRA, sought to begin the process of standardizing regional anaesthesia documentation by means of a Delphi consensus project.⁶ This latest research highlighted the complexities faced when attempting to standardize practices across jurisdictions and healthcare systems. The documentation requirements of all anaesthesia providers vary significantly depending on their individual preferences, the medicolegal climate in which they practice and the requirement of documentation for remuneration purposes. The availability of electronic medical records also featured heavily in this work with respect to their potential to automate much of the routine documentation that is required for regional anaesthesia and thus reduce this burden for clinicians. These issues need to be considered when implementing this research into guidelines and individual practice.

This presentation will address the most recent research in documentation in regional anaesthesia and the challenges this may present to the clinician.

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SP46 REGIONAL ANAESTHESIA IN A DIABETIC PATIENT

G Crowe, B Atterton, Moran EM Louise. *Letterkenny University Hospital, Letterkenny, Ireland*

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Diabetes Mellitus is the most common endocrine disorder globally.¹ A diagnosis of diabetes is a risk factor for peri-operative complications however this risk can be mitigated with improved blood glucose control and individualised peri-operative management. There are numerous potential advantages of utilising regional anaesthesia for patients with diabetes. These include a reduction in post-operative nausea and vomiting, avoidance of possible airway complications associated with general anaesthesia and a reduction in opioid use and length of stay.²

Unfortunately, there are also risks associated with performing regional anaesthesia on the patient with diabetes, especially those with acquired diabetic neuropathy (DN). DN increases the sensitivity of nerves to local anaesthetics and regional anaesthesia blocks can be excessively prolonged,³ delaying mobilisation. DN also makes nerve stimulation techniques more difficult as nerves are harder to stimulate (often >1.0mA required) which may result in the needle tip being closer to the nerve than perceived. The neurotoxic effects of local anaesthetics, especially with the addition of vasoconstricting adjuvants, are accentuated in DN. Finally, there is an increased risk of peri-neural catheter infection, therefore heightened vigilance is required to recognise this important complication.⁴

The decision to perform regional anaesthesia on patients with diabetes should be taken after careful consideration of the risks and benefits.

This problem based learning presentation will review the advantages and disadvantages of using regional anaesthesia in diabetic patients.

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SP47 UPPER LIMB SURGERY: HOW DO I DO IT?

MP Sebastian. *Royal National Orthopaedic Hospital, Stanmore, UK*

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In 1912 L.Eloesser¹ stated that any part of the body subserved by a simple combination of nerves which anatomical course admits be reached by a needle without damage to adjacent structures, are amenable to regional anaesthesia (RA).

This statement remains in force, with the advantage that nowadays, we are able to see those nerves, the needle and the adjacent structures, making RA safer and more effective.

The upper limb's innervation comes mainly from the brachial plexus (BP) and most of the surgeries on the upper limb can be done under RA alone.

Different approaches of the BP, provide different surgical anaesthesia/analgesia because nerves emerge from the BP at different levels along its course. A thorough knowledge of the BP anatomy is essential to succeed.

The BP is formed by the ventral primary rami of cervical nerves 5 to 8 (C5–C8) and the first thoracic nerve (T1) with