Journal of Clinical Anesthesia 66 (2020) 109948

Contents lists available at ScienceDirect

Journal of Clinical Anesthesia

journal homepage: www.elsevier.com/locate/jclinane

Correspondence

Interfascial plane blocks as shortcut alternatives for regional anesthesia and pain management for SARS-CoV-2 days: Not deeper, not longer. Be safe for everyone

Dear editor,

SARS-CoV-2 (COVID-19) has been a problem for the whole world since the beginning of 2020, and the war against this virus should be the top priority of all healthcare professionals. Elective surgical procedures have been delayed or significantly reduced. Many issues that were our first priority before the pandemic have now been pushed into the background. The anesthesiology community has been testing new methods for opioid sparing anesthesia and analgesia for years and setting in these methods as a principle in the protocols we chose; we cannot currently, due to the Covid-19 pandemic condemn patients to opioids [1–3].

In this article, we want to emphasise the main target as perioperative analgesia and chronic pain management, and we describe what we believe is the right way forward for achieving this goal. In recent years, metanalyses have been published showing that the use of interfacial blocks as part of multimodal analgesia reduces postoperative opioid requirement in surgical patients [4]. We have some suggestions in the analgesia plan of patients that are suspect of having or have been diagnosed with COVID-19.

1. As before, during this period, interfacial plan blocks should be continued and patients should be given as few opioids as possible during the postoperative period.
2. To reduce the number of visits to patients rooms and therefore minimize contact, long-acting local anesthetics should be preferred in interfacial blocks. Interfacial catheter placement and the use of a patient-controlled analgesia device, if available, would be a good option.
3. For the safety of practitioners and operating room workers, interfacial blocks that require as minimal patient positioning as possible should be preferred. As in abdominal and thoracic surgeries, when bilateral block application is required in the side position, blocks that can be performed with a single position should be selected (such as bilateral ESPB in the side position). In lower abdominal surgeries, if it is predicted to provide sufficient sensorial blockage, transversalis fascia plan block application can be preferred to quadratus lumborum block (QLB) and ESPB.
4. Blocks such as PVB, QLB type 3 are deep blocks and needle visibility/dominance is low in these blocks. More superficial, easier and safer blocks should be preferred. While we want to improve the quality of postoperative analgesia, we should minimize the risks that may occur in patients and healthcare professionals. Blocks, in which bleeding-related complications are almost never reported, should be the first options-such as ESPB and PECs.
5. LAST is a condition we would not want in a patient with COVID-19 diagnosis/suspect, as with all other patients. In interfacial blocks, we can provide postoperative analgesia and avoid LAST by using low concentration and normal/high volumes.
6. Applications with fluoroscopy are still used frequently in chronic pain management. However, both the length of the procedure and sometimes the need for multiple manipulation should be avoided in patients diagnosed with COVID-19. USG guided ESPB applications can be applied instead of cervical-thoracic-lumbar epidural injections, facet injections, medial branch injections, sacral foraminal injections, and the processing time is very short. It has been reported that ESPB can be used in place of epidural injections and LA spread has been shown radiologically [5].

One of the most important issues is the careful use of personal protective equipment and the preparation and disinfection of the procedure room. The screen and control panel of the ultrasound machine must be covered with disposable plastic covers to protect it from contamination.

We, the authors, have presented our professional comments and suggestions on the use of interfacial blocks in this unusual time frame. There is a need for comprehensive guidelines on regional anesthesia in the pandemic process which appears will last longer than expected.

https://doi.org/10.1016/j.jclinane.2020.109948
Received 6 May 2020; Received in revised form 23 May 2020; Accepted 29 May 2020
0952-8180/ © 2020 Elsevier Inc. All rights reserved.

References

[1] Wagh HD. Advocate for regional anesthesia in the corona pandemic? Reg Anesth Pain Med 2020. https://doi.org/10.1136/rapm-2020-101464. In press.

[2] Soberon Jr. JR, Urdaneta F. Regional anesthesia during the COVID-19 pandemic: a time to reconsider practices? (Letter #1). Can J Anaesth 2020. https://doi.org/10.1007/s12630-020-01681-w. In press.

[3] Altiparmak B, Korkmaz Toker M, Uysal AI, Gumus Demirbilek S. Regional anesthesia in patients with suspected COVID-19 infection. Reg Anesth Pain Med 2020. https://doi.org/10.1136/rapm-2020-101477. In press.

[4] Kendall MC, Alves L, Traill LL, De Oliveira GS. The effect of ultrasound-guided erector spinae plane block on postsurgical pain: a meta-analysis of randomized controlled trials. BMC Anesthesiol 2020;20:99.

[5] Celik M, Tulgar S, Ahiskalioglu A, Alper F. Is high volume lumbar erector spinae plane block an alternative to transforaminal epidural injection? Evaluation with MRI. Reg Anesth Pain Med 2019. https://doi.org/10.1136/rapm-2019-100514. In press.

Serkan Tulgar[a], Ali Ahiskalioglu[b,c,*], David Terence Thomas[d], Yavuz Gurkan[e]

[a] *Maltepe University Faculty of Medicine, Department of Anesthesiology and Reanimation, Istanbul, Turkey*

[b] *Ataturk University School of Medicine, Department of Anesthesiology and Reanimation, Erzurum, Turkey*

[c] *Clinical Research, Development and Design Application and Research Center, Ataturk University School of Medicine, Erzurum, Turkey*

[d] *Maltepe University Faculty of Medicine, Department of Pediatric Surgery and Medical Education, Istanbul, Turkey*

[e] *Koc University, Department of Anesthesiology and Reanimation, Istanbul, Turkey*

E-mail address: ali.ahiskalioglu@atauni.edu.tr (A. Ahiskalioglu).

[*] Corresponding author at: Ataturk University School of Medicine, Department of Anesthesiology and Reanimation, 25070, Erzurum, Turkey; Clinical Research, Development and Design Application and Research Center, Ataturk University School of Medicine, 25240 Erzurum, Turkey.