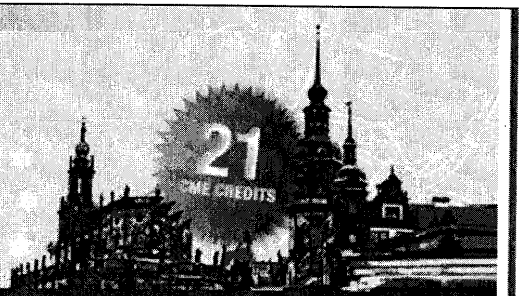
THE EUROPEAN SOCIETY OF REGIONAL ANAESTHESIA

ESRA

30th Annual ESRA Congress 2011

Building Knowledge and Science in Regional Anaesthesia



Dresden, Germany, September 7-10, 2011

REGIONAL ANAESTHESIA CONGRESS

A multi-disciplinary group of healthcare providers from around the world who specialize in pain management are expected to attend the 30th Annual European Society for Regional Anaesthesia Congress. Participants will have the opportunity to gain practical experience and to share and explore the latest clinical evidence, best practices and industry updates.

Come learn and network with over 1,500 anaesthesiologists, physicians and scientists who specialize in regional anaesthesia for surgery, obstetrics, paediatrics and pain control in the lovely, historic town of Dresden.

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On-line registration is now closed.

REGISTRATION DESKS

On Site Registration Desk will be open at the Maritim Hotel & International Congress Center Dresden as follows:

Wednesday, September 7	08:00-20:00
Thursday, September 8	07:30-18:45
Friday, September 9	07:30-18:00
Saturday, September 10	07:30-13:00

this report we document a new guidance method much simpler than CT guidance and much more reliable than blind methods. It describes an ultrasound guidance technique which has not been reported previously. Our technique avoids the difficulty of having to identify the suprascapular notch. Huge variability in this structure has been reported. **Methods:** The case was 62 years old lady who had been suffering from bilateral shoulder pain and tenderness for 2 years that did not respond to more conservative measures. Suprascpaular nerve block in this lady was done under aseptic conditions using a portable ultrasound scanner and a curvilinear transducer (4-5MHz) (SonoSite Micromaxx SonoSite, Inc. 21919 30th Drive SE Bothwell W. A.). The transducer was placed in a transverse orientation over the base of the neck to identify the clavicle anteriorly and the suprascapular fossa posteriorly. The suprascapular fossa was traced laterally to the direction of the acormium and suprascapular notch. A 22G spinal needle was guided by real-time ultrasound imaging to the lateral aspect of the suprascapular fossa and 2.5% chirocaine and Triamcinalone was injected in the floor of the fossa. Doppler was used to avoid any intravascular injection.
Results: This provided pain relief for a period of 4 months and no complications were reported.
Conclusions: Utrasound guidance is much simpler and more reliable and provides comparable pain relief

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FACILITATION OF DIAGNOSTIC AND PERCUTANEOUS TRIAL LEAD PLACEMENT WITH ULTRASOUND GUIDANCE FOR PERD?HERAL NERVE STIMULATION SUPRASCAPULAR NEURALGIA

B. Bouche, E. Eisenberg, S. Narouze, M.K. Karmakar, M. Meignier, J. Lemarie *France, USA, Hong Kong SA.R.*
Backgroud and aims: Osteoarthritis with adhesive capsulitis or pain after multiple shoulder surgery or traumatic are intractable painfull .Medications, nerve injections.radiofrequency ablation.pulsed radiofrequency modulation, surgical nerve transposition and SCS have been attempted as treatment options to treat usually nerve involved:suprascapular.We describe case 5 reports series Peri-Nervous Stimulation (PNS) with UltraSound (US) guidance in diagnostic and implantation for suprascapular neuralgia . **Methods:** All treatment options were unsuccesfull. The first step (regional test) is US guidance (Sonosite,M Turbo®) for perinervous underwelling catheterization on implicated nerve.The US transducer locates the nerve in the suprascapular notch.depth beneath the transverse scapular ligament.If the test is successful (VAS< 3), the second step is US guidance nerve localization for trial PNS.Under US visualization.the lead (Boston lead®) is placed as closed to the nerve. After the trial PNS,permanent peripheral stimulator is implanted (Boston®).
Results: Follow up on patients implanted is over 12 months.Prior to regional test and PNS implantation.pain scale (VAS) varies between 6 and 8/10. All decrease less than 2/10 by the end of the two trials.AU no longer requires any pain medications and pain rates are 0 to 4/10 at 12 months follow up.3/5 patients who were working before neuralgias, return to work. No complications (infections.leads problems...) occurred.
Conclusions: US guidance is allows optimal placement of underwelling catheter and stimulator leads , minimizes trauma and decreases both operative and post operative complications.US guidance has a important role for US guidance in localization of targeted nerve,suprascapular, in PNS trial.

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SUPRASCAPULAR NERVE BLOCK IN CHRONIC SHOULDER PAIN

E. Antonopoulou, T. Kelgiorgis, G. Georgiopoulos, E. Tsevreni, P. Florou *Greece.*
Background and aims: This is a retrospective study to assess the effectiveness of suprascapular nerve block to relieve pain and improve the range of movement in degenerative disease of shoulder.
Methods: We studied 104 patients, 33 men and 71 women aged 60.56±10.87,with chronic shoulder pain. The patients were in pain for a period more than 3 months and had junctional disability due to degenerative disease. We performed suprascapular nerve block with 10 ml of levobupi-vacaine 2.5 mg/ml using anatomical landmarks and a nerve stimulator to determine needle placement. Thirty minutes later the patients had physiotherapy session. They were given instructions to do specific exercise for as long as the block lasted. A series of 4-6 suprascapular nerve blocks were performed to the patients. We recorded pain scores and range of movement. The follow up was 12 weeks.
Results: The success rate of the block was 99.5 %. There was significant improvement in all pain scores (pain at rest, at night and at movement) 90% in all patients. Pain VAS score was 2-3 occasionally, during the follow up . The range of movement improved 80-90% in all patients. There were no significant adverse effects in the patients due to the peripheral nerve block.
Conclusions: Suprascapular nerve block is an easy and safe method to perform with minimum side effects and very effective in the management of chronic shoulder pain, which is a common clinical problem.

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FLUOROSCOPY GUIDED CERVICAL INTERLAMINAR STEROID) INJECTIONS IN PATIENTS WITH CERVICAL PAIN SYNDROMES: A RETROSPECTIVE STUDY

S.G. Beyaz, *Turkey.*
Background and aims: Epidural steroid injections are frequently used for relieving pain due to spinal pathologies and cervical pain syndromes. The objective of this retrospective study was to examine the efficacy of fluoroscopically guided cervical interlaminar epidural steroid injections (CILESI).
Methods: Sixty-five patients who received their first fluoroscopically guided CILESI over 12 months interval were retrospectively identified. Patients who had railed conservative non-surgical management and patients who were otherwise candidates of surgery were included in this trial of CILESI. The verbal numerical rating scales (VNRS) before the treatment, within one hour after the treatment and upon follow-up were analyzed. **Results:** The most preferred intervention level of CILESI was C5-C6. There was a statistically significant improvement in the VNRS scores from before the injection to immediately after the injection, and upon follow-up. Fifty-one patients (80%) had perfect/good scores. No major complications were encountered after CILESI, but one patient had (1.54%) vasovagal reaction and another 1 patient had (1.54%) transient increase of pain after injection.
Conclusions: Fluoroscopy guided CILESI is a safe and effective means of treating patients with cervical pain syndromes. The success rates show that a large percentage of the patients may obtain relief from radicular symptoms and avoid surgery for the follow-up period up to 12 months.

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DO SMALL BURNS MATTER?

G. Camilleri, R. Griffiths
Background: Few studies have examined the prevalence of neuropathic pain in patients following burns. Previous studies were performed mostly in patients with large total body surface area (TBSA) burns and identified a prevalence of sensory disturbance of 71%[1] and 82%[2] and pain of 36%[1], 35%[2] and 52%[3]. We wished to explore the prevalence of neuropathic pain in patients with small (< 5%) TBSA burns and the impact of this injury.
Methods: A descriptive, cross-sectional study was designed to examine the prevalence of neuropathic pain more than 6 months following injury. Fifteen consecutive patients with <5% TBSA burn were sent a DN4 Neuropathic Pain Questionnaire to elicit the diagnosis of neuropathic pain. Patients also commented on whether the neuropathic pain affected normal daily activities. Size, depth and location of the burn were obtained from the medical notes.
Results: 9 patients (60%) completed a DN4 questionnaire 6 months after their injury. Average TBSA burn was 1.5%. 44% developed neuropathic pain