

Use of Preoperative TAP-Block with Two Different Concentrations of Ropivacaine: A Comparison in the Perspective of an Opioid-Sparing Approach in Emergency Abdominal Surgery

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ABSTRACT

Clinical studies have evaluated TAP block showing positive analgesic effects. In the literature there are not many reports on the use of TAP-Block in abdominal surgery in emergency - urgency setting. We evaluated 12 patients divided into two groups (A, B) who underwent pre-operative TAP-Blocks with two different mixtures of local anesthetic: group A was administered the mixture with Ropivacaine 0.375% and adjuvants, while group B the mixture with Ropivacaine 0.45%, Mepivacaine 0.5% and adjuvants was administered. In group B there was a lower need for opioid administration both intraoperatively and postoperatively. Furthermore, in most cases pain control upon awakening was superior in group B compared to group A.

Keywords: TAP; TAP-Block; Abdominal surgery; Emergency setting

ABBREVIATIONS

IOT: Orotracheal Intubation; TAP: Transversus Abdominis Plane; NRS: Numeric Rating Scale; RASS: Richmond Agitation Sedation Scale; TAPO: Antalgic Post-Operative Therapy; NSAIDs: Non-Steroidal Anti-inflammatory Drugs

INTRODUCTION

Transversus Abdominis Plane (TAP) blocks can provide postoperative analgesia for a variety of surgical procedures. A lot of clinical studies have evaluated TAP block showing positive analgesic effects [1]. Multimodal opioid-sparing analgesia is a key component of the Enhanced Recovery After Surgery (ERAS) protocol for the management of postoperative pain. Transversus Abdominal Plane (TAP) block has contributed to the implementation of this approach in several types of surgical procedures [2]. Regional anesthesia for abdominal wall procedures can be performed using a variety of peripheral nerve blocks. These blocks are typically Ultrasound (US) guided and involve injecting a Local Anesthetic (LA) solution into interfascial planes. US-guided Transversus Abdominis Plane

(TAP) block involves the injection of LA in between the Transversus Abdominis (TA) and Internal Oblique (IO) muscles. The TAP block can also be targeted using anatomical landmarks at the level of the Petit triangle [3]. This interfascial plane contains the intercostal, subcostal, iliohypogastric, and ilioinguinal nerves [3]. Ultrasound guidance is now considered the gold standard in TAP blocks. It is easy to acquire ultrasound images; it can be used in many surgeries involving the anterolateral abdominal wall. The nomenclature regarding TAP block is confusing, and there is still no consensus about its terminology after an explosive growth in numbers of studies about it [4]. A review from 2017 provided a nomenclature system to categorize the various approaches into four groups comprising subcostal, oblique subcostal, lateral, and posterior TAP blocks. The classification is based on the involved spinal nerves rather than the probe positions only [4]. In this study we wanted to study the oblique subcostal block of the Transversus Abdominis Plane (TAP-Block) under ultrasound guidance to evaluate the possibility of further reducing the need for the use of opioid/NSAIDs drugs in emergency abdominal surgery. There are studies in the literature that have evaluated the efficiency of this technique in an elective setting, examining a mixture of local

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anesthetic different from the one we used. We therefore evaluated the effects of a different mixture in emergency abdominal surgery, comparing it with a mixture similar to the one already evaluated.

MATERIALS AND METHODS

We consulted the competent ethics committee about this work and received a positive opinion. Thirty abdominal surgery patients who had the following characteristics were included in the study retrospectively: emergency surgery, exploratory laparotomy surgery, awakening in the operating room. Patients who were unable to recover in the operating room were excluded. These patients were given general anesthesia with the administration of intravenous anaesthetics, Fentanyl at a dosage of 100 mcg to cover pain during Orotracheal Intubation (IOT) and Rocuronium at a dosage of 1.2 mg/kg to perform IOT in rapid sequence. Fifteen patients were selected in group A for whom a preoperative bilateral ultrasound-guided TAP-Block oblique-subcostal was performed with Ropivacaine 0.375% and adjuvants, at a volume of 20 ml per side, compared with fifteen patients included in group B for whom a preoperative ultrasound-guided TAP-Block oblique subcostal was performed with Ropivacaine 0.45%+Mepivacaine 0.5% and adjuvants [4]. All patients received an analgesic starter with Paracetamol 1 g iv, except for only one case which was not possible due to reported allergies. In this only case the analgesic starter was carried out through the administration of Clonidine 150 mcg intramuscularly. The Group A local anesthetic mixture was obtained by taking 10 ml of Ropivacaine 7.5 mg/ml, Dexamethasone 1 ml (2 ml vial for 8 mg) and Clonidine 0.1 ml (1 ml vial for 150 mcg), all diluted with 8.9 ml of 0.9% NaCl solution to reach a total volume of 20 ml and a concentration of Ropivacaine 0.375%. The Group B local anesthetic mixture was obtained by taking 12 ml of Ropivacaine 7.5 mg/ml, 5 ml of Mepivacaine 20 mg/ml, Dexamethasone 1 ml (2 ml vial for 8 mg), Clonidine 0.1 ml (1 ml vial for 150 mcg), all diluted with 3.9 ml of 0.9% NaCl solution to reach a total volume of 20 ml,

a concentration of Ropivacaine 0.45% and a concentration of Mepivacaine 0.5%. For each patient, the intensity of pain upon awakening and 24 hours after surgery was assessed using the NRS rating scale, the state of agitation upon awakening and 24 hours after using RASS scale.

OBJECTIVES

In the literature there are not many reports on the use of TAP-Block in abdominal surgery in emergency-urgency setting. We therefore wanted to use this procedure in a different occasion than elective surgery, setting as a primary objective the saving of analgesic drugs (opiates and FANS) both during the maintenance of anesthesia and in the control of post-operative pain. The primary endpoints chosen were pain control during the maintenance of general anesthesia, evaluated through hemodynamic stability and the possible need for administration of opiate analgesic drugs, the sensation of pain upon awakening of the patient and the related state of agitation, evaluated through the NRS and RASS scales, pain control 24 hours after the end of the surgical procedure, evaluated through the NRS and RASS scales.

RESULTS

In group A, in ten out of fifteen cases, the administration of opiates was necessary while maintaining general anesthesia (Fentanyl or Remifentanyl) for optimal pain control. In eleven out of fifteen cases, the use of morphine was also necessary to control pain in the 24 hours following the operation. In 34 cases out of 15 the patients complained of pain upon awakening, while in only one case out of fifteen was agitation noted. In group B, only three case required the use of opioids during maintenance, while the prescription of opioids/FANS was never necessary to control post-operative pain in the 24 hours following surgery. Furthermore, upon awakening in only two case out of fifteen did the patient complain of mild pain (NRS 1) (Table 1).

Table 1: Comparison of postoperative pain (NRS, RASS) and opioid use in emergency abdominal surgery patients receiving preoperative TAP block.

Group A	Awake NRS	Awake RASS	24h NRS	24h RASS	Opioids Mainten.	Opioids/FANS TAPO
1	2	1	0	0	YES	YES
2	0	0	0	0	YES	NO
3	0	0	0	0	YES	YES
4	0	0	0	0	NO	YES
5	3	0	0	0	NO	NO
6	0	0	0	0	YES	YES
7	0	0	0	0	YES	YES
8	0	0	0	0	YES	YES

9	2	0	0	0	YES	YES
10	0	0	0	0	YES	NO
11	0	0	0	0	NO	YES
12	1	0	0	0	YES	YES
13	0	0	0	0	YES	NO
14	0	0	0	0	NO	YES
15	0	-1	0	0	NO	YES

Group B	Awake NRS	Awake RASS	24h NRS	24h RASS	Opioids Mainten.	Opioids/EANS TAPO
1	0	0	0	0	NO	NO
2	0	0	0	0	NO	NO
3	0	0	0	0	NO	NO
4	0	0	0	0	NO	NO
5	1	0	0	0	YES	NO
6	0	0	0	0	NO	NO
7	0	0	0	0	NO	NO
8	0	0	0	0	NO	NO
9	0	0	0	0	NO	NO
10	0	0	0	0	YES	NO
11	1	0	0	0	YES	NO
12	0	0	0	0	NO	NO
13	0	0	0	0	NO	NO
14	0	-1	0	0	NO	NO
15	0	-1	0	0	NO	NO

DISCUSSION

In the literature there are several reports on the use of this procedure both in colorectal surgery, in pelvic surgery, and in obstetric anesthesia, where it was concluded that the TAP-Block can be considered a safe and effective additional method for pain relief after cesarean delivery [2,5]. It has been demonstrated that pre-operative TAP-Block with a mixture of local anesthetic Ropivacaine 0.375% and adjuvants is useful in significantly reducing the use of opioid drugs and NSAIDs both for intraoperative and post-operative pain control [6]. However, in many cases, the use of Remifentanyl during maintenance of general anesthesia and post-operative pain therapy with an

elastomeric pump is often necessary [6]. In this work, having used a different mixture with a slightly higher concentration of Ropivacaine, we studied the possibility of reducing, if not abolishing, the use of intra- and post-operative opioid drugs, with the exception of 100 mcg of Fentanyl necessary for the pain related to orotracheal intubation. In summary we can say that we have achieved superior intraoperative and postoperative pain control in Group B (mixture with Ropivacaine 0.45%, Mepivacaine 0.5% and adjuvants) compared to Group A (mixture with Ropivacaine 0.375% and adjuvants); furthermore, in Group B there was a significantly lower use of intraoperative and postoperative Opiates/NSAIDs compared to Group A. It would be interesting to evaluate, on this type of patients, the

benefits of opioid-sparing approach on the time of return of normal enteric activity and on hospitalization times, considering the negative effects of opioid drugs on intestinal functionality [7].

CONCLUSION

Since the primary objective of the study was the opioid sparing policy in emergency abdominal surgery, we can state that in this study we had a better result in group B than in group A.

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