be used as untreated hypotension can seriously damage the unborn infant.

After delivery of the baby, syntocinon is the oxytocic of choice as it is less likely to produce maternal nausea and vomiting than ergometrine.

Further reading:
Collins C, Gurug A. Anaesthesia for Caesarean section. Update in Anaesthesia 1998;9:7-17
Torr GI. James MFM. The role of the anaesthetist in pre-eclampsia. Update in Anaesthesia 1998;9:17-22

POSTOPERATIVE ANALGESIA IN PAEDIATRIC DAY CASE SURGERY

Paediatric day case surgery was first described in 1909 by James Nicoll, who performed 8988 operations as day case at the Royal Glasgow Hospital. Since then, day case surgery has continued to grow and now about 50% to 60% of paediatric surgery is performed as outpatients in most of the western countries like USA and UK. In India, the incidence of paediatric day case surgery is low, i.e., 35%. This is because of illiteracy, lack of proper transport facilities and unhygienic conditions at home.

Key to success in paediatric day case surgery is proper selection of patients, prevention of common postoperative complications and adequate pain management. Severe postoperative pain not only decreases the patients’ functional capacity but also is associated with longer postoperative stay and higher incidence of unanticipated readmission. Pain may precipitate postoperative nausea vomiting (PONV) which is another cause of unanticipated readmission. Hence adequate pain management is mandatory in day case surgery.

Planning for postoperative analgesia must be done during the preoperative visit, keeping in mind the age, psychological and ASA status of the patient, and the type of surgery. Appropriate assessment of pain is essential for providing optimal analgesia.

ASSESSMENT

Numerous scoring systems are available for assessment of pain in paediatric patients. Each system has its own advantages and disadvantages. Selection of scoring systems mainly depends upon the age of the child.

Neonates. Day case surgery is not contraindicated in full term neonates - minor procedures like examination under anaesthesia and incision and drainage can be performed. Fortunately, these procedures do not produce much postoperative pain.

A variety of assessment tools have been developed for neonates. Observation of facial expression, body position and movement, crying, arterial pressure, heart rate, skin colour, ventilatory frequency and sleeplessness are used to find out the severity of pain in neonates. But these parameters can be altered by non-painful stimuli. Therefore a more rational approach is to assess the improvement of behavioural or physiological parameters in response to comfort, analgesia or sedation.

Infants and Children up to 3 years. Like neonates, assessment of pain in this age group of children is also based on behavioural and physiological response to comfort and analgesic therapy. Though exhibited behaviour may be more vigorous with an “all or nothing” type of response, sometimes the response is more precise and they can locate the pain. Objective pain scale (OPS) and toddler-preschooler postoperative pain scale (TPPPS) are commonly used to assess the intensity of pain.

Children aged 3 to 7 years. These patients can differentiate the presence or absence of pain and locate the pain. They can also express the intensity of pain in the form nil, mild, moderate and severe. The face scale or Oucher scale can be used in this age group. Children of five or more years old can operate visual or colour analogue scales for expression of pain.
Older Children. Like adults, children more than seven years old can express intensity, location and quality of pain. Any scoring system such as horizontal VAS, vertical colour analogue scale and self reporting are effective and reliable.

MANAGEMENT OF POSTOPERATIVE PAIN

Operative procedures associated with severe postoperative pain should not be performed as day surgery. For most patients postoperative pain should not be a major problem provided that local anaesthesia and NSAID have been used either as a part of the anaesthetic technique or after completion of surgery. Oral analgesics are the mainstay of pain relief at home.

Topical Anaesthesia. EMLA cream is an eutectic mixture of prilocaine and lignocaine and is very effective at providing dermal anaesthesia. Topical EMLA decreases the pain associated with circumcision, release of preputial adhesion, myringotomies and skin grafting. To obtain effective analgesia cream should be applied to the skin with an occlusive dressing about 45 to 60 minutes prior to surgery. Duration of analgesia is about 1 hour. EMLA should be used with caution in infants less than 3 months of age or in patients who are taking sulphonamides or other methaemoglobin inducing medications because of potential of methaemoglobinemia.

Lignocaine gel can be used to provide analgesia following circumcision and after repairs of lacerations. Parents can be taught to apply the gel for postoperative analgesia during first 24-36 hours. Application of bupivacaine and epinephrine (adrenaline) on the open wound towards the end of surgery provides excellent analgesia. Topical local anaesthetic eye drops can be used to provide analgesia following ophthalmic surgery.

Instillation. Bupivacaine instillation before closure of small wounds is very effective. Continuous infusion of 0.25% bupivacaine through a small cannula at a rate of 1-3mls/hour provides a simple, safe and effective method of analgesia at the donor site of skin graft or iliac crest bone graft.

Wound infiltration. Local anaesthetic agents may be administered intradermally or subcutaneously to block impulse conduction in local nerve fibres. Surgical wound infiltration can be used to provide analgesia following skin biopsies, muscle biopsies and virtually all procedures where other regional blocks are either inappropriate or contraindicated.

Caudal epidural block is widely used in paediatric patients to provide analgesia following surgery below the level of the umbilicus. With a single injection, it provides long lasting postoperative analgesia in paediatric day case surgery.

Caudal block is achieved by injecting local anaesthetic agents into the epidural space through the sacral hiatus, which is situated 1 to 2cm above the gluteal crease, superior to the coccyx and between the prominent sacral cornuae. The sacral hiatus can be located by drawing an equilateral triangle of which the two superior angles overlie the posterior superior iliac spines and third angle overlies the sacral hiatus (see Update in Anaesthesia No. 9 1998).

Under general anaesthesia the patient is placed in the lateral position. The skin is prepared using a standard sterile technique. The block is performed using a short bevelled needle of less than 3cm length to reduce the incidence of accidental dural puncture. The needle is inserted through the sacral hiatus at a 45 degree angle pointing rostrally (towards the head). Once the sacroccocygeal ligament is punctured the angle of the needle is decreased to 20 degrees. Approximately 0.75 to 1ml/kg of local anaesthetic agent is required for analgesia up to T10 level.

Weakness of the lower limbs associated with caudal block may delay the discharge of the patient. This can be minimised by using weaker local anaesthetic solutions such as 0.125% bupivacaine. Another drawback of single shot caudal block is its short duration. The duration can be prolonged by adding drugs such as clonidine α2 agonist, in a dose of 1-2mcg/kg or preservative free ketamine in a dose of 0.5mg/kg. Morphine and other spinal opioids are not recommended for paediatric day case surgery because of the risk of delayed respiratory depression.

Peripheral Nerve Block. Peripheral nerve blocks such as penile block, inguinal block, fascia iliaca block and sciatic nerve block have been demonstrated to be as effective as single shot caudal block. Moreover they produce longer lasting analgesia.

Penile block is performed to provide analgesia following circumcision, minor hypospadias surgery and other distal penile procedures. Different techniques have been described to block penile nerves including a midline and paramedian approaches. The paramedian approach is often preferred due to a lower incidence of complications such as intravascular injection, haematome and ischaemia. A short bevelled needle is inserted perpendicular to the skin at the inferior edge of the symphysis pubis at the 11 and 10o’clock positions. The needle is advanced until Bucks fascia is penetrated, which is determined by a loss of resistance. After careful aspiration plain 0.5% bupivacaine 1ml + 0.1ml/kg is administered. For better effect,
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subcutaneous infiltration of local anaesthetics at the base of the penis from 3 to 9 o’clock position is recommended. However a full ring block should be avoided.

Ilioinguinal and iliohypogastric blocks provide effective analgesia after inguinal herniotomy and orchidopexy. The quality and duration of analgesia achieved by this block are comparable to caudal block. A short bevelled 22 to 25 gauge needle is inserted, one patient’s finger breadth medial to anterior superior iliac spine. After penetrating the external oblique aponeurosis and the internal oblique muscle fascia, a sudden loss of resistance is felt and the local anaesthetic can be deposited after a negative aspiration test. A dosage of 0.4 ml/kg of 0.25% bupivacaine with or without adrenaline is used for unilateral ilioinguinal and iliohypogastric nerve blocks. Another injection immediately lateral to pubic tubercle to block the nerves coming from the opposite side and local infiltration along the line of incision improve the quality of analgesia. In about 50% patients the subcostal nerve accompanies the iliohypogastric nerve and may be responsible for inadequate pain relief. Therefore a more effective block can be achieved by an injection directed laterally to contact the inside wall of the ilium and infiltrating local anaesthetic as the needle is withdrawn slowly. For pain relief after orchidopexy ilioinguinal and iliohypogastric blocks must be combined with local infiltration of the scrotum. This is because the inferior aspect of the scrotum is innervated by the pudendal nerve.

Brachial plexus block may be used to provide postoperative analgesia following upper extremity surgery. The axillary approach is the safest, more reliable and most commonly used in children and may provide useful analgesia for operations below the elbow.

Positioning of the patient is very important to make the artery (which is surrounded by the nerve plexus) palpable. The child is placed supine and the arm is abducted to 90 degrees and rotated externally. The forearm is flexed to 90 degrees. A short bevelled needle is inserted perpendicular to skin at the most proximal part at which the artery can be palpated. The needle is advanced until a “fascial click” is felt. At this point arterial pulsation is usually transmitted to needle. These two signs indicate that the needle tip is within the fascial sheath. After a negative aspiration test, local anaesthetic agent may be injected. Bupivacaine 0.25%, 0.6ml/kg is usually adequate. A two point injection technique, i.e., one above and another below the artery improves the success rate.

Femoral nerve block and 3 in 1 blocks are indicated in day surgery to provide analgesia following skin grafting where the graft is taken from thigh and muscle biopsies. However due to the effect on the leg muscles, postoperative mobilisation is significantly affected which may delay discharge.

The femoral nerve is situated just lateral to the femoral artery below the inguinal ligament deep to the fascia lata and iliaca. Therefore when the needle is advanced, 2 losses of resistance must be felt. Usually 0.25% bupivacaine 0.3ml/kg is enough for adequate blocks of the femoral nerve (see Update in Anaesthesia No. 11 2000).

In a 3 in 1 block apart from the femoral nerve, the lateral cutaneous nerve of thigh and obturator nerve are also blocked. The volume of local anaesthetic should be doubled so that it can spread adequately between the iliacus fascia and muscle to reach the other nerves. Distal pressure on the femoral sheath during and after the injection improves the quality of nerve block.

Greater auricular nerve block. This nerve innervates most of the pinna and may be blocked to provide excellent analgesia after otoplasty. The block is performed by injecting 0.5% bupivacaine 1ml subcutaneously between the mastoid process and the descending ramus of the mandible.
Systemic Analgesics

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) along with local anaesthesia are the mainstay of postoperative pain relief in paediatric day case surgery. They have several advantages over opioid analgesics including a lack of respiratory depression and sedation. They do not cause nausea or vomiting.

NSAIDs have been found to be very effective analgesics in older children. However use of these agents are not recommended below one year of age due to the possibility of immature renal function and hepatic metabolism. Diclofenac, ibuprofen and ketorolac are the most commonly used agents. Administration of these agents before surgery as a premedicant provides optimal analgesia due to their anti-inflammatory activity.

Bronchospasm induced by NSAIDs is very rare in children and asthma is not a contraindication to the use of NSAIDs. However one should avoid them if the child has been recently or repeatedly hospitalised with asthma, or has required steroids systemically, or is known to be NSAID sensitive (Table 1).

Paracetamol (acetaminophen) is a very safe and effective analgesic in children including infants and neonates. Oral paracetamol 20mg/kg as a premedication is useful in achieving therapeutic plasma concentration postoperatively. The total daily dose of paracetamol can be up to 90mg/kg/day for the first 3 days in healthy children. This should be reduced to 60mg/kg/day in neonates (Table 2). The drug may be administered rectally but higher doses are necessary, due to poor and erratic absorption through the rectal mucosa.

Opioids are not ideal for paediatric day case surgery as they may produce ventilatory depression, excessive sedation and postoperative nausea and vomiting. With some procedures however opioids are required during and after surgery to control pain. Shorter acting opioids are ideal - fentanyl (1-2mcg/kg) is commonly used. Longer acting opioids (morphine / pethidine) may be required if postoperative pain is unexpectedly severe. Although the procedure may have been planned on a day case basis unexpected hospital admission may be required for control of severe pain.

Non Pharmacological Therapy may be helpful in some children. It includes distraction techniques like playing with toys, watching videos, music and hypnotic therapy. The child may be allowed to stay in a friendly atmosphere preferably with parents in the immediate postoperative period. All these measures reduce analgesic requirement and speeds recovery.

Conclusion

Postoperative pain following day case surgery in paediatric patients is usually not severe and diminishes within 3 to 5 days. Peripheral nerve blocks by local anaesthetic agents provide optimal analgesia in the immediate postoperative period. Patients should not be discharged until pain is well controlled with oral medications such as paracetamol, ibuprofen or diclofenac.

Further Reading


| Table 1: Doses of NSAIDs in Paediatric Patients |
|-------------------|------------------|
| NSAID            | Dose mg/kg | Maximum dose mg/kg/day |
| Ibuprofen        | 10         | 40                   |
| Diclofenac       | 1          | 3                    |
| Kеторолак         | 0.5        | 2                    |
| Naproxen         | 7.5        | 15                   |
| Индометацин      | 1          | 3                    |

| Table 2: Dose of Paracetamol (Orally) |
|-------------------|------------------|
| Loading dose      | 20 mg/kg         |
| Maintenance dose  | 15 mg/kg         |
| Maximum dose      | 90 mg/kg/day (Older children) |
|                   | 60 mg/kg/day (Neonates) |
INTRAOSSEOUS INFUSION

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Key Points
- Intraosseous infusion is a temporary emergency measure
- Indicated in life-threatening situations when intravenous access fails (3 attempts or >90 seconds)
- Use the anteromedial aspect of the tibia
- Insert pointing caudal to avoid the epiphyseal growth plate
- Use an aseptic technique
- Crystalloids, colloids, blood products and drugs can be infused
- Remove as soon as the child has been resuscitated and intravenous access has been established

Introduction
The technique of intraosseous infusion was first described in humans in 1934 and it became increasingly popular in the 1940s. In recent years it has regained popularity especially in paediatric resuscitation. Unfortunately many doctors do not know this technique or do not employ it. However, intraosseous infusion is one of the quickest ways to establish access for the rapid infusion of fluids, drugs and blood products in emergency situations as well as for resuscitation. In many countries children are the victims of war trauma, road traffic accidents or severe dehydration and need good intravenous access, this technique can be life-saving. In these situations peripheral venous access can be difficult to obtain and alternatives such as central venous access can be difficult and/or dangerous.

Introduction to the technique
The marrow cavity is in continuity with the venous circulation and can therefore be used to infuse fluids and drugs, and to take blood samples for crossmatch, for example. The procedure must be performed under sterile conditions to avoid causing osteomyelitis. It is also recommended to limit the duration of the use of intraosseous infusion to a few hours until intravenous access is achieved. It is thus a temporary emergency measure. In experienced hands intraosseous access can be established within 1 minute.

It has been shown that the onset of action and drug levels during cardiopulmonary resuscitation using the intraosseous route are similar to those given intravenously.

Indications
Placement of an intraosseous needle is indicated when vascular access is needed in life-threatening situations in babies, infants and children under the age of six years. It is indicated when attempts at venous access fail (three attempts or 90 seconds) or in cases where it is likely to fail and speed is of the essence. Although principally advocated for use in young children, it has been successfully used in older children where the iliac crest may also be used.

Contra-indications
- Femoral fracture on the ipsilateral side
- Do not use fractured bones
- Do not use bones with osteomyelitis

Equipment
1. Skin disinfectant
2. Local anaesthetic
3. 5 ml syringe
4. 50ml syringe
5. Intraosseous infusion needle or Jamshidi bone marrow needle. There are different needle sizes; 14, 16 and 18G. The 14 and 16G are usually used for children older than 18 months. However any size can be used for all ages.

It is possible but not ideal to use a 16 – 20G butterfly needle, spinal needle or even hypodermic needle. The chance that the needle gets blocked with bone marrow however, is much increased when not using a needle with a trochar.

Site
The best site to use is the flat anteromedial aspect of the tibia. The anterior aspect of the femur and the superior
iliac crest can also be used. The tibia is preferred since the anteromedial aspect of the bone lies just under the skin and can easily be identified. Avoid bones with osteomyelitis or fractures and do not use the tibia if the femur is fractured on the same side.

**Technique**

1. Palpate the tibial tuberosity. The site for cannulation lies 1 - 3cm below this tuberosity on the anteromedial surface of the tibia.

2. Use sterile gloves and an aseptic technique and a sterile needle.

3. Clean the skin. Placing a bone marrow needle without using a sterile technique obviously increases the chance of osteomyelitis and cellulitis.

4. Inject a small amount of local anaesthetic in the skin and continue to infiltrate down to the periostium. When the child is unconscious it is not necessary to use local infiltration.

5. Flex the knee and put a sandbag as support behind the knee.

6. Hold the limb firmly above the site of insertion, usually at the level of the knee. Avoid putting your hand behind the site of insertion to avoid accidentally injuring your own hand.

7. Insert the intraosseous needle at 90 degrees to the skin (perpendicular) and slightly caudal (towards the foot) to avoid the epiphysial growth plate.

8. Advance the needle using a drilling motion until a 'give' is felt – this occurs when the needle penetrates the cortex of the bone. Stop inserting further.

9. Remove the trochar. Confirm correct position by aspirating blood using the 5ml syringe. If no blood can be aspirated the needle may be blocked with marrow. To unblock the needle, slowly syringe in 10 ml of saline. Check that the limb does not swell up and that there is no increase in resistance.

10. If the tests are unsuccessful remove the needle and try the other leg.

11. Secure the needle in place with sterile gauze and strapping.

Correct placement is further confirmed by the following:

- A sudden loss of resistance on entering the marrow cavity (less obvious in infants who have soft bones).

- The needle remains upright without support (because infants have softer bones, the needle will not stand as firmly upright as in older children).

- Fluid flows freely through the needle without swelling of the subcutaneous tissue.

**Complications**

Important complications are tibial fracture especially in neonates, compartment syndrome, osteomyelitis and skin necrosis. When an aseptic technique is used, the incidence of osteomyelitis is less than 1%. Microscopic pulmonary fat and marrow emboli do not seem to be a clinical problem. Provided the correct technique is employed there does not seem to be any long-term effects on bone growth.

**Infusion**

Fluid can be infused under gentle pressure, manually by using a 50ml syringe or by inflating a blood-pressure cuff around the infusion bag. Crystalloids, blood products and drugs can be infused using this technique.

The intraosseous route should be replaced as soon as a normal vein can be cannulated and certainly within a few hours. The longer the period of use the greater the risk of complications.
Conclusion

In emergencies rapid intravenous access in children may be difficult to achieve. Intraosseous access is an easy, safe and life-saving alternative.

References

ANSWERS - MULTIPLE CHOICE

1. TFFTF
Increasing HR will increase oxygen consumption. CO = HR x Stroke Volume, and SV is proportional to preload, contractility and afterload. DM may cause an autonomic neuropathy, this can give rise to an abnormal Valsalva response. PA catheters assume a continuous column of blood from the catheter tip to the left ventricle with no pressure gradients, in mitral stenosis there is a gradient between left atrium and the left ventricle.

2. FFTTF
In spontaneous ventilation the Mapleson A is extremely efficient and requires a FGF of approximately 70ml/kg/min. The Jackson Rees circuit has an open bag.

3. FFTTF
Soda lime: 94% calcium hydroxide, 5% sodium hydroxide and 1% potassium hydroxide, with a bit of silica. When fresh, soda lime contains 35% water. At the start of a case circle systems need to be denitrogenated with higher gas flows.

4. TFFFF
b) GCS 8. The patient in c) should have any haemodynamic instability resolved even if this requires laparotomy, i.e. ABC before all else. Avoid nasogastric tubes if there is a chance of skull fracture. Tension pneumothoraces should be decompressed as emergencies before an X-ray is taken.

5. FFTTF
The oculo-cardiac reflex is mediated by the parasympathetic nerve supply via the vagus. Normal IOP is 10-20mmHg. Ketamine and suxamethonium are not ideal agents for use in induction in these cases but sometimes there are no alternatives e.g. patients with a full stomach.

6. FFFTT
Renal blood supply is 20% of CO. The juxtaglomerular complex produces renin, which via aldosterone promotes K+ excretion in the distal tubule. ANP has an anti renin and anti angiotensin II effect as well as increasing GFR.

7. TFFFF
Maintenance fluid is 4/2/1mls/kg/hr respectively for the first, second and subsequent 10kgs of weight. Infants have a higher closing volume that encroaches upon tidal volumes. Alveolar MV is 100-150ml/kg/min due to higher oxygen demand.

8. TFTFT
Resuscitation fluid bolus is 20ml/kg. Children with pyloric stenosis should have their biochemistry and hydration corrected prior to surgery.

9. FFTTF
Patients with type II block should have a cardiological referral to consider pacing. Patients with chronic lung conditions are susceptible to hypoventilation and superadded infection, and where available an epidural could be an appropriate form of analgesia. MI patients should avoid all non-urgent surgery for >3months (ideally 6).

10. TTTFF
Other causes of EMD include; hypovolaemia, hypothermia, and electrolyte imbalance.