

Helping Patients Understand Regional Blocks

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THE BETTER PATIENTS understand surgery and anesthesia, the more likely they are to accept regional anesthesia—or even demand it. That’s why we have invested in a regional anesthesia outreach program that helps shatter the myths patients harbor.

Our program consists of several parts. Foremost, we perform one-on-one pre-op counseling. Patients often fear blocks initially, and they may express fear as ‘refusals.’ We don’t automatically accept these refusals. Instead, we help patients evaluate the reasons for their feelings, and they often realize their fears are unfounded.

During the pre-anesthetic visit, we give patients a take-home risk disclosure form that outlines the technique, expected results, and risks of each mode of anesthesia. The form helps patients think through their options, and when we sign this form with our patients, it serves as documentation of informed consent for anesthesia. Our institution also maintains a storefront in our local mall, where we distribute a regional anesthesia flyer. We have also invited the news media to cover regional anesthesia, with good results.

With all forms of communication, we follow two key rules. First, we present the case for regional anesthesia before highlighting the risks. Just as a surgeon talks about the appropriateness of a surgical procedure before reviewing the complications, we talk about how regional anesthesia provides superior pain control with less chance of making the patient sleepy and nauseated. At first, this requires a lot of thought, because anesthesia providers are more used to focusing on risks than benefits. Now that we have switched our focus, however, educating patients has become more enjoyable,

Choosing Regional Anesthesia to Improve Your Recovery from Surgery

Your surgeon may have already discussed with you some of the options you have available for types of anesthesia: general, local, or regional anesthesia. This decision depends on what you want, what your anesthesiologist recommends, and what your surgeon wants. If your surgery involves your arm (shoulder and down), your leg (hip and down), or an incision in your chest or abdomen, regional anesthesia is usually a good option to consider.

Regional anesthesia is part of our routine at Wake Forest University Baptist Medical Center. Hundreds of our patients benefit from regional anesthesia every month. Simply put, regional anesthesia is putting a part of your body to sleep by using numbing medicine injected through a needle. In many cases numbing medicines can also be given by a catheter for several days. In this case, physicians of the Regional Anesthesia and Acute Pain Management Team (see photo) will visit you after surgery to help your surgeon prevent pain. Most patients prefer that regional anesthesia be combined in the OR with medicines given through an i.v. to provide relaxation and sleep.

It is our routine to begin giving i.v. medicines even before the OR and even before we place any needles. For some surgeries, regional anesthesia must be combined with deep unconsciousness followed by a breathing tube in the OR. There are other surgeries, medical conditions, or surgeon requests where it is better to avoid some types of regional anesthesia or to use only general anesthesia. As with any type of surgical or medical treatment, side effects are possible. For regional anesthesia, these are incomplete pain relief, soreness or bruising at the needle site, or tingling that lasts for days. Spinals and epidurals can cause headaches about 1% of the time. Serious complications are fortunately very rare and are similar to those from a surgery: infection, injury from bleeding, or injury to a nerve.



Some proven advantages of regional anesthesia are better pain relief, less narcotic use, earlier mobility, less nausea, better bowel function, and (for some surgeries) less blood loss and less risk of blood clots.

Three Types of Regional Anesthesia

Peripheral Nerve Blocks: A needle or catheter is placed along the path of nerves to your arm or leg. Numbing medicine is injected to provide 4-20 hours of pain relief. If a peripheral nerve block catheter is used, numbing medicine given continuously prevents pain for days—plus you will have a button to safely give yourself more numbing as you need it. Always, you will have back-up pain medicines available by mouth or your i.v.

Epidurals: A needle is placed between the bones of the back for injection of pain relieving medicines. Sometimes, epidural pain medicine specially formulated to last two days is injected through this needle. Other times, a better choice is a small catheter left in place. Then, continuous numbing and pain relieving medicines given through this epidural catheter (along with a button for extra doses) will help prevent pain. In either case, you can lie, sit and usually walk with an epidural. Commonly, we use this catheter for several days during your recovery—usually until you are able to take pills to easily control pain.

Spinals: A thin needle is placed between the bones of your back, and a single injection of numbing medicines is made to numb both legs. We choose spinal medicines so they last from 1 to 8 hours.

We distribute this brochure at the local mall; it emphasizes the positives of regional anesthesia before enumerating the risks.

and patients seem more satisfied. Second, we use simple, non-threatening language. For example, providers often describe general anesthesia in a comforting way, as “sleep,” yet present nerve blocks using terms that are too technical or scary to patients—like “electrical current,” “nerve stimulation,” “paresthesia” or “catheter.” Patients need to know what will happen. They don’t need to know the intricacies. We also make a point to accurately describe the IV medications administered during regional anesthesia as producing “sleep,” and we distinguish them from the “general anesthesia that requires a breathing tube.”

When more patients opt for regional anesthesia, we don’t need to switch gears between patients. We can streamline our procedures, keep protocols consistent, and spend less time managing general

anesthetics and their side effects. This gives us more freedom to focus on the patients themselves and shows on a personal level that we are doing our best to reduce risk and help them get better, faster.



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