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Lunchtime Drop-in Sessions

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Title: Infraorbital and infratrochlear nerve blocks combined with general anaesthesia for outpatient rhinoseptoplasty: A prospective randomised, double-blind, placebo-controlled study.

Citation: Anaesthesia, critical care & pain medicine, Feb 2016, vol. 35, no. 1, p. 31-36, 2352-5568 (February 2016)

Author(s): Boselli, Emmanuel, Bouvet, Lionel, Augris-Mathieu, Caroline, Bégou, Gérard, Diot-Junique, Nathalie, Rahali, Najia, Vertu-Ciolino, Delphine, Gérard, Cécile, Pivot, Christine, Disant, François, Allaouchiche, Bernard

Abstract: We conducted a study to determine the efficacy of bilateral extraoral infraorbital and infratrochlear nerve blocks during outpatient rhinoseptoplasty under general anaesthesia. In this prospective, double-blind, randomised, controlled trial, 40 adult patients undergoing outpatient rhinoseptoplasty under general anaesthesia were assigned to receive bilateral infraorbital and infratrochlear nerve blocks with either 10mL of 0.25% levobupivacaine (Group LB) or isotonic saline (control group). Patients in Group LB received 0.1mL/kg of isotonic saline as a placebo and patients in the control group received 0.1mL/kg of morphine. The primary endpoint was total perioperative morphine consumption (intraoperative and in the post-anaesthesia care unit). The secondary endpoints were pain scores, time spent in the post-anaesthesia care unit and the outpatient ward, block-related complications and patient satisfaction. The total dose of perioperative morphine was lower in Group LB than in the control group (2.5±2.8mg versus 9.5±3.5mg, respectively, P<0.001). The mean±SD or median [IQR] times spent in the post-anaesthesia care unit (60±10min and 78±33min, respectively, P<0.03) and in the outpatient ward (210 [178-223] min versus 275 [250-300] min, respectively, P<0.001) were lower in Group LB than in the control group. There were no differences between groups for other endpoints. Bilateral extraoral infraorbital and infratrochlear nerve blocks performed with 0.25% levobupivacaine during general anaesthesia combining remifentanil and desflurane reduce the perioperative dose of morphine and the time spent in the post-anaesthesia care unit and the outpatient ward in adult patients undergoing outpatient rhinoseptoplasty.

Title: Less Pain 1 Year After Total Extra-peritoneal Repair Compared With Lichtenstein Using Local Anesthesia: Data From a Randomized Controlled Clinical Trial.

Citation: Annals of surgery, Feb 2016, vol. 263, no. 2, p. 240-243, 1528-1140 (February 2016)

Author(s): Westin, Linn, Wollert, Staffan, Ljungdahl, Mikael, Sandblom, Gabriel, Gunnarsson, Ulf, Dahlstrand, Ursula

Abstract: The aim was to compare long-term postoperative pain after inguinal hernia surgery using 2 techniques that have shown favorable long-term outcome in previous randomized studies: Lichtenstein using local anesthesia (LLA) and endoscopic total extra-peritoneal repair (TEP) under general anesthesia. Patients often experience pain after inguinal hernia surgery. These 2 methods in their optimal state have not yet been sufficiently compared. A randomized controlled trial was
conducted to detect any difference in long-term postoperative inguinal pain. Altogether 384 patients were randomized and operated using either TEP under general anesthesia (n = 193) or LLA (n = 191). One year postoperatively, patients were examined by an independent surgeon and requested to complete the Inguinal Pain Questionnaire (IPQ), a validated questionnaire for the assessment of postoperative inguinal pain. Three hundred seventy-five (97.7%) patients completed follow-up at 1 year. In the TEP group, 39 (20.7%) patients experienced pain, compared with 62 (33.2%) patients in the LLA group (P = 0.007). Severe pain was reported by 4 patients in the TEP group and 6 patients in the LLA group (2.1% and 3.2%, respectively, P = 0.543). Pain in the operated groin limited the ability to exercise for 5 TEP patients and 14 LLA patients (2.7% and 7.5%, respectively, P = 0.034). Patients operated with TEP experienced less long-term postoperative pain and less limitation in their ability to exercise than those operated with LLA. The present data justify recommending TEP as the procedure of choice in the surgical treatment of primary inguinal hernia.

Title: Neuraxial vs general anaesthesia for total hip and total knee arthroplasty: a systematic review of comparative-effectiveness research.

Citation: British journal of anaesthesia, Feb 2016, vol. 116, no. 2, p. 163-176, 1471-6771 (February 2016)

Author(s): Johnson, R L, Kopp, S L, Burkle, C M, Duncan, C M, Jacob, A K, Erwin, P J, Murad, M H, Mantilla, C B

Abstract: This systematic review evaluated the evidence comparing patient-important outcomes in spinal or epidural vs general anaesthesia for total hip and total knee arthroplasty. MEDLINE, Ovid EMBASE, EBSCO CINAHL, Thomson Reuters Web of Science, and the Cochrane Central Register of Controlled Trials from inception until March 2015 were searched. Eligible randomized controlled trials or prospective comparative studies investigating mortality, major morbidity, and patient-experience outcomes directly comparing neuraxial (spinal or epidural) with general anaesthesia for total hip arthroplasty, total knee arthroplasty, or both were included. Independent reviewers working in duplicate extracted study characteristics, validity, and outcomes data. Meta-analysis was conducted using the random-effects model. We included 29 studies involving 10 488 patients. Compared with general anaesthesia, neuraxial anaesthesia significantly reduced length of stay (weighted mean difference -0.40 days; 95% confidence interval -0.76 to -0.03; P=0.03; I² 73%; 12 studies). No statistically significant differences were found between neuraxial and general anaesthesia for total hip arthroplasty, total knee arthroplasty, or both were included. Subgroup analyses failed to find statistically significant interactions (P>0.05) based on risk of bias, type of surgery, or type of neuraxial anaesthesia. Neuraxial anaesthesia for total hip or total knee arthroplasty, or both appears equally effective without increased morbidity when compared with general anaesthesia. There is limited quantitative evidence to suggest that neuraxial anaesthesia is associated with improved perioperative outcomes. Future investigations should compare intermediate and long-term outcome differences to better inform anaesthesiologists, surgeons, and patients on importance of anaesthetic selection.

Title: Cervical epidural analgesia in current anaesthesia practice: systematic review of its clinical utility and rationale, and technical considerations.

Citation: British journal of anaesthesia, Feb 2016, vol. 116, no. 2, p. 192-207, 1471-6771 (February 2016)
**Author(s):** Shanthanna, H, Mendis, N, Goel, A

**Abstract:** Cervical epidural analgesia (CEA) is an analgesic technique, potentially useful for surgeries involving the upper body. Despite the inherent technical risks and systemic changes, it has been used for various surgeries. There have been no previously published systematic reviews aimed at assessing its clinical utility. This systematic review was performed to explore the perioperative benefits of CEA. The review was also aimed at identifying the rationale of its use, reported surgical indications and the method of use. We performed a literature search involving PubMed and Embase databases, to identify studies using CEA for surgical indications. Out of 467 potentially relevant articles, 73 articles were selected. Two independent investigators extracted data involving 5 randomized controlled trials, 17 observational comparative trials, and 51 case reports (series). The outcomes studied in most comparative studies were on effects of local anaesthetics and other agents, systemic effects, and feasibility of CEA. In one randomized controlled study, CEA was observed to decrease the resting pain scores after pharyngo-laryngeal surgeries. In a retrospective study, CEA was shown to decrease the cancer recurrence after pharyngeal-hypopharyngeal surgeries. The limited evidence, small studies, and the chosen outcomes do not allow for any specific recommendations based on the relative benefit or harm of CEA. Considering the potential for significant harm, in the face of better alternatives, its use must have a strong rationale mostly supported by unique patient and surgical demands. Future studies must aim to assess analgesic comparator effectiveness for clinically relevant outcomes. © The Author 2016. Published by Oxford University Press on behalf of the British Journal of Anaesthesia. All rights reserved. For Permissions, please email: journals.permissions@oup.com.

**Title:** Use of local anesthetic (0.25% bupivacaine) for pain control after pediatric cardiac catheterization: A randomized controlled trial.

**Citation:** Catheterization and cardiovascular interventions : official journal of the Society for Cardiac Angiography & Interventions, Feb 2016, vol. 87, no. 2, p. 318-323, 1522-726X (February 1, 2016)

**Author(s):** Palma, Amy, Viegas, Jacqueline, Manlhiot, Cedric, McCrindle, Brian, Benson, Lee

**Abstract:** To investigate the effects of local infiltration of 0.25% bupivacaine on post-operative pain and analgesic use in children undergoing cardiac catheterization procedures. In pediatric catheterization procedures performed under general anesthesia, a local anesthetic is often used prior to femoral sheath removal. There are no published reports of the impact of local anesthetic infiltration on pain after pediatric procedures, and mixed reports on its effectiveness in adults. A randomized controlled trial was undertaken of 140 children, aged 7-18 years undergoing cardiac catheterization under general anesthesia via the femoral vein or artery. Participants received a subcutaneous infiltration of 0.25% bupivacaine at the access site prior to sheath removal, or usual care without bupivacaine. Outcomes included patient reported pain scores and analgesic use up to 6 hr after the procedure. Pain scores were similar between groups through the 6-hr post-procedure period. The proportion of children reporting a maximal pain score of ≤2/10 was higher in the bupivacaine group (64% vs. 44%, P = 0.03). A significantly higher proportion of children in the control group required IV morphine (18.8% vs. 4.5%, P = 0.02). Morphine use can be reduced with the use of 0.25% bupivacaine given prior to femoral sheath removal and should be considered for post-procedural pain control for pediatric patients undergoing cardiac catheterization. This study is the first to contribute evidence to the effectiveness of 0.25% bupivacaine after pediatric cardiac catheterization. © 2015 Wiley Periodicals, Inc. © 2015 Wiley Periodicals, Inc.
Title: The effect of an anaesthetic patient information video on perioperative anxiety: A randomised study.

Citation: European journal of anaesthesiology, Feb 2016, vol. 33, no. 2, p. 134-139, 1365-2346 (February 2016)

Author(s): Lin, Shun-Yuan, Huang, Hung-An, Lin, Sung-Chun, Huang, Yuan-Ting, Wang, Kuo-Yang, Shi, Hon-Yi

Abstract: Despite growing evidence that an educational anaesthesia video can effectively reduce perioperative anxiety, the ideal medium for addressing perioperative anxiety is unclear. The purpose of this study was to investigate the effect of viewing an anaesthetic patient information video on anxiety levels in patients scheduled to undergo surgery. A randomised controlled trial. Pingtung Christian Hospital (PTCH), Taiwan. One hundred patients were randomised to either an experimental group (n = 50) or a control group (n = 50). At the preoperative clinic, the experimental group watched the an 8 min educational anaesthetic video, whereas the control group received a standard 8-min verbal briefing on anaesthesia after preoperative assessment. The Chinese version of the Spielberger state trait anxiety inventory, which included a state scale (STAI-S) and a trait scale (STAI-T), was performed in the preoperative clinic (T1) before anaesthetic preassessment, at the preoperative holding area just before surgery (T2) and again on the third day after surgery (T3). Scores for overall satisfaction with medical care were obtained on the third day after surgery. For two time interval comparisons, effect size was used to standardise the extent of change as measured by STAI-S. After the educational intervention, state anxiety was lower in the experimental group than in the control group at both T2 (42.9 ± 6.5 vs. 45.0 ± 12.7) and T3 (40.2 ± 5.3 vs. 48.8 ± 8.5). Compared with control group, the experimental group had a larger effect size at T2 and T3 (-0.65 and -0.36, respectively). Overall satisfaction was significantly higher in the experimental group than in the control group (P < 0.05). Perioperative anxiety was significantly reduced and overall patient satisfaction increased after viewing a preoperative educational anaesthesia video compared with a standard verbal briefing on anaesthesia.

Title: Hysteroscopic local anesthetic intrauterine cornual block in office endometrial ablation: a randomized controlled trial.

Citation: Fertility and sterility, Feb 2016, vol. 105, no. 2, p. 474, 1556-5653 (February 2016)

Author(s): Kumar, Vinod, Tryposkiadis, Konstantinos, Gupta, Janesh Kumar

Abstract: To evaluate the efficacy of a hysteroscopic local anesthetic intrauterine cornual block (ICOB) on pain experienced during office endometrial ablation (EA) in addition to a traditional direct local anesthetic cervical block (DCB). Prospective, randomized, double-blind, placebo-controlled trial. University teaching hospital. Women with heavy menstrual bleeding scheduled for an office endometrial ablation. Before office EA, DCB plus hysteroscopic ICOB just medial to each tubal ostium using local anesthetic mixture made up of 1 mL 3% mepivacaine plus 1 mL 0.5% bupivacaine versus control group receiving DBC plus ICOB with 2 mL of placebo (saline). pain reported during procedure via visual analogue scale (VAS) from 0 to 10; secondary outcomes: postoperative pain, rescue analgesic requirement, and duration of hospital stay. Most characteristics were similar across groups. The mean VAS score during the procedure was statistically significantly lower by 1.44 (95% confidence interval, -2.65 to -0.21) in the active group compared with the placebo group. There were no statistically significant differences between the two groups in the postprocedural mean VAS
scores, rescue analgesic requirement, or duration of hospital stay. Used in addition to DCB, ICOB reduces the pain experienced during office EA compared with DCB alone. NCT01808898. Copyright © 2016 American Society for Reproductive Medicine. Published by Elsevier Inc. All rights reserved.

Title: Predictors and outcomes following naloxone administration during Phase I anesthesia recovery.

Citation: Journal of anesthesia, Feb 2016, vol. 30, no. 1, p. 116-122, 1438-8359 (February 2016)

Author(s): Weingarten, Toby N, Chong, Elisa Y, Schroeder, Darrell R, Sprung, Juraj

Abstract: To identify characteristics associated with postoperative respiratory depression that required naloxone intervention during Phase I recovery following general anesthesia. A secondary aim is to compare postoperative outcomes between patients who received naloxone and those who did not. Patients who received naloxone to reverse opioid-induced respiratory depression or sedation during Phase I postanesthesia recovery from January 1, 2010 to December 31, 2013 were identified and matched to 2 controls based on age, sex, and surgical procedure during the same year. A chart review was performed to identify factors associated with risk for intervention requiring naloxone as well as to note the occurrence of adverse postoperative outcomes. Analyses to assess characteristics potentially associated with naloxone use were performed using conditional logistic regression taking into account the 1:2 matched set case-control study design. Naloxone was administered to 413 patients, with an incidence of 2.5 per 1000 anesthetics [95 % confidence interval (CI) 0.7-6.5]. Presence of obstructive sleep apnea [odds ratio (OR) = 1.74, 95 % CI 1.22-2.48, P = 0.002], ASA Physical Status (PS) ≥III (OR 1.44, 95 % CI 1.08-1.92, P = 0.013), and greater opioid administration (OR 1.22, 95 % CI 1.12-1.33, per 10 intravenous morphine equivalents mg, P < 0.001) were associated with naloxone administration. Naloxone administration was associated with increased adverse events (OR 3.39, 95 % CI 2.22-5.23, P < 0.001). Obstructive sleep apnea, higher ASA-PS scores and greater doses of intraoperative opioids were associated with naloxone administration during Phase I recovery. Patients administered naloxone had increased adverse events after discharge from the recovery room and may benefit from a higher level of postoperative care.

Title: Five-year follow-up of a randomized, controlled trial comparing saphenofemoral ligation and stripping of the great saphenous vein with endovenous laser ablation (980 nm) using local tumescent anesthesia.

Citation: Journal of vascular surgery, Feb 2016, vol. 63, no. 2, p. 420-428, 1097-6809 (February 2016)

Author(s): Gauw, Stefanie A, Lawson, James A, van Vlijmen-van Keulen, Clarissa J, Pronk, Pascal, Gaastra, Menno T W, Mooij, Michael C

Abstract: The objective of this study was to compare the long-term results (groin-related recurrence, great saphenous vein [GSV] occlusion rate, Clinical class, Etiology, Anatomy, and Pathophysiology [CEAP] staging, and quality of life [QoL]) after the treatment of a GSV incompetence by saphenofemoral ligation and stripping (SFL/S) with endovenous laser ablation bare fiber, 980 nm (EVLA). Patients with GSV insufficiency and varicose veins were randomized to either undergo SFL/S or EVLA, both of which were performed under tumescent anesthesia. The long-term results, which included the anatomic occlusion rate, varicose vein recurrence at the saphenofemoral junction (SFJ), relief of venous symptoms and QoL, were compared up to 5 years after treatment. A total of 130
legs of 121 patients were treated with either SFL/S (n = 68) or EVLA (n = 62). In the first 12 months, three recanalizations of the GSV were observed after EVLA. Up to 5 years later, more recurrent varicose veins caused by neoreflux in incompetent tributaries of the SFJ were observed after EVLA (31%; 19/61) compared with SFL/S (7%; 4/60; P < .01). Neovascularization in the groin with clinically visible recurrence identified at 3 and 5 years post-treatment follow-up was only observed in the SFL/S group (n = 6). After 5 years, clinically visible recurrences originating from the SFJ region after EVLA were observed 33% (20/61) compared with 17% of patients (10/60) after SFL/S (P < .04). In both treatment groups, venous symptoms improved significantly. Patients in both groups reported a continuing significant cosmetic improvement measured on a visual analog scale of 1 to 10 (mean, 7.49; P < .01). There was no difference in the CEAP staging and a standardized, non-disease-specific instrument for describing and valuing health states (EuroQol-5D), between the groups up to 5 years after follow-up. At the 5-year follow-up, a significantly higher varicose vein recurrence rate originated at the SFJ region after EVLA compared with SFL/S. There were no differences in the relief of venous symptoms, CEAP staging, or general QoL between the groups. Copyright © 2016 Society for Vascular Surgery. Published by Elsevier Inc. All rights reserved.

Title: The effect of Valsalva maneuver in attenuating skin puncture pain during spinal anesthesia: a randomized controlled trial.

Citation: Korean journal of anesthesiology, Feb 2016, vol. 69, no. 1, p. 27-31, 2005-6419 (February 2016)

Author(s): Kumar, Sanjay, Gautam, Sujeet Kumar Singh, Gupta, Devendra, Agarwal, Anil, Dhirraj, Sanjay, Khuba, Sandeep

Abstract: Valsalva maneuver reduces pain by activating sinoaortic baroreceptor reflex arc. We planned this study to evaluate the role of valsalva in attenuating spinal needle-puncture pain. Ninety American Society of Anesthesiologists (ASA) grade I and II enrolled patients undergoing elective surgery were randomized into 3 groups of 30 each. Group I (Control): didn’t blow; group II (Distraction): patients blew into rubber tube; Group III (Valsalva): blew into sphygmomanometer tube and raise mercury column up to 30 mmHg for at least 20 seconds. During above procedures, spinal puncture was performed with 25-gauge spinal needle. Eighty-two patient data were analyzed. Incidence of spinal puncture pain was reduced to 10% (3 of 27) in Valsalva group as compared to 100% (28 of 28 in control group and 27 of 27 in Distraction group) observed in other two groups (P < 0.05). Severity of lumbar puncture pain as assessed by visual analog scale (0-10; where 0 is no pain and 10 is the worst imaginable pain) presented as Median (Interquartile range) were significantly reduced in the Valsalva group (0.0 [0.0] as compared to other 2 groups 2.0 [0.0] in the Distraction group and 3.0 [0.8] in Control group) (P < 0.05). Regarding time taken by CSF to fill spinal needle hub, there was no difference among the three groups (P > 0.05). None patient of all groups had post dural puncture headache (P > 0.05). Valsalva can be performed routinely in ASA I and II patients undergoing spinal anesthesia as it is safe, painless and non-pharmacological method of pain attenuation.

Title: The Effects of Dexmedetomidine on Myocardial Function Assessed by Tissue Doppler Echocardiography During General Anesthesia in Patients With Diastolic Dysfunction: A CONSORT-Prospective, Randomized, Controlled Trial.

Citation: Medicine, Feb 2016, vol. 95, no. 6, p. e2805., 1536-5964 (February 2016)
**Author(s):** Lee, Su Hyun, Na, Sungwon, Kim, Namo, Ban, Min Gi, Shin, Sung Eui, Oh, Young Jun

**Abstract:** Dexmedetomidine is a commonly used sedative and adjuvant agent to general anesthesia. The present was designed to evaluate the effects of dexmedetomidine on myocardial function by using tissue Doppler echocardiography during general anesthesia in patients with diastolic dysfunction. Forty patients undergoing orthostatic surgery with ejection fraction preserved diastolic dysfunction grade 2 or 3 were randomly allocated to the Control and Dex group (n = 20, each). In the Dex group, dexmedetomidine was given as an initial loading dose of 1.0 μg/kg over 10 minutes followed by a maintenance dose of 0.5 μg/kg/h. The ratio of peak early diastolic transmitral or transtricuspid inflow velocity to early diastolic mitral or tricuspid annular velocity (LV or RV E/e’) and left or right ventricular myocardial performance index (LV or RV MPI) were measured at before and after the administration dexmedetomidine or saline. The Dex group showed significant decrease of heart rate (P = 0.038), and increase of mean blood pressure (P < 0.001), LV E/e’ (P = 0.025), and LV MPI (P < 0.001) compared to those of the Control group on a linear mixed model analysis. Also, the Dex group showed significant increase of RV E/e’ (P < 0.001) and RV MPI (P = 0.028) compared to those of the Control group. Intraoperative dexmedetomidine administration during general anesthesia was appeared to deteriorate biventricular function in patients with diastolic dysfunction. We suggest careful consideration and a need for reducing dosage when administrating dexmedetomidine in patients with diastolic dysfunction.

**Title:** Management of Postoperative Pain: A Clinical Practice Guideline From the American Pain Society, the American Society of Regional Anesthesia and Pain Medicine, and the American Society of Anesthesiologists’ Committee on Regional Anesthesia, Executive Committee, and Administrative Council.

**Citation:** The journal of pain : official journal of the American Pain Society, Feb 2016, vol. 17, no. 2, p. 131-157, 1528-8447 (February 2016)

**Author(s):** Chou, Roger, Gordon, Debra B, de Leon-Casasola, Oscar A, Rosenberg, Jack M, Bickler, Stephen, Brennan, Tim, Carter, Todd, Cassidy, Carla L, Chittenden, Eva Hall, Degenhardt, Ernest, Griffith, Scott, Manworren, Renee, McCarberg, Bill, Montgomery, Robert, Murphy, Jamie, Perkal, Melissa F, Suresh, Santhanam, Sluka, Kathleen, Strassels, Scott, Thirlby, Richard, Viscusi, Eugene, Walco, Gary A, Warner, Lisa, Weisman, Steven J, Wu, Christopher L

**Abstract:** Most patients who undergo surgical procedures experience acute postoperative pain, but evidence suggests that less than half report adequate postoperative pain relief. Many preoperative, intraoperative, and postoperative interventions and management strategies are available for reducing and managing postoperative pain. The American Pain Society, with input from the American Society of Anesthesiologists, commissioned an interdisciplinary expert panel to develop a clinical practice guideline to promote evidence-based, effective, and safer postoperative pain management in children and adults. The guideline was subsequently approved by the American Society for Regional Anesthesia. As part of the guideline development process, a systematic review was commissioned on various aspects related to various interventions and management strategies for postoperative pain. After a review of the evidence, the expert panel formulated recommendations that addressed various aspects of postoperative pain management, including preoperative education, perioperative pain management planning, use of different pharmacological and nonpharmacological modalities, organizational policies, and transition to outpatient care. The recommendations are based on the underlying premise that optimal management begins in the preoperative period with an assessment of the patient and development of a plan of care tailored to the individual and the surgical procedure involved. The panel found that evidence supports the use
of multimodal regimens in many situations, although the exact components of effective multimodal care will vary depending on the patient, setting, and surgical procedure. Although these guidelines are based on a systematic review of the evidence on management of postoperative pain, the panel identified numerous research gaps. Of 32 recommendations, 4 were assessed as being supported by high-quality evidence, and 11 (in the areas of patient education and perioperative planning, patient assessment, organizational structures and policies, and transitioning to outpatient care) were made on the basis of low-quality evidence. This guideline, on the basis of a systematic review of the evidence on postoperative pain management, provides recommendations developed by a multidisciplinary expert panel. Safe and effective postoperative pain management should be on the basis of a plan of care tailored to the individual and the surgical procedure involved, and multimodal regimens are recommended in many situations.

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British Journal of Anaesthesia
March 2016, Volume 116, Issue 3

Current Opinion in Anaesthesiology
April 2016, Volume 29, Issue 2
New NICE Guidance

QS113 Healthcare-associated infections

Quick exercise

Match the study design with the timeframe it covers.

1. Randomised Controlled Trial
2. Cross-Sectional Study
3. Case-control Study
4. Cohort Study

Case Report Upcoming

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