INTRODUCTION of ultrasound as a monitor of needle placement and disposition of the local anesthetic has had a significant impact on the clinical practice of peripheral nerve blocks. In particular, the ability to visualize the interaction between needle and anatomy in real time has led to an increase in the use and success of peripheral nerve blocks. Not surprisingly, ultrasound guidance has inspired the development of a multitude of new block techniques, previously unreliable because of the inability to position a needle tip consistently in a tissue plane or adjacent to sensory nerves. A few examples include transverse adductor canal, transversus abdominis plane, and pectoralis blocks; all enthusiastically discussed at regional anesthesia gatherings and online discussion forums.‡ However, before widespread adoption, scrutinizing the novel approaches in high-quality, randomized, controlled trials is necessary to document a favorable impact on the clinical practice of peripheral nerve blocks. Not surprisingly, ultrasound guidance has inspired the development of a multitude of new block techniques, previously unreliable because of the inability to position a needle tip consistently in a tissue plane or adjacent to sensory nerves. A few examples include transverse adductor canal, transversus abdominis plane, and pectoralis blocks; all enthusiastically discussed at regional anesthesia gatherings and online discussion forums.‡ However, before widespread adoption, scrutinizing the novel approaches in high-quality, randomized, controlled trials is necessary to document a favorable impact on the clinical practice of peripheral nerve blocks.

“[Dr. Jæger et al. provide] new information that may have potentially significant ramifications for walking the tightrope of optimizing analgesia while retaining quadriceps strength after major knee surgery.”

Photo: ©Thinkstock.

Accepted for publication October 2, 2012. Funding for this project was provided by the Department of Anesthesiology, University of California, San Diego (San Diego, California). Dr. Ilfeld has received research funding from several infusion pump manufacturers, including Baxter International Healthcare (Deerfield, Illinois), Smiths Medical (St. Paul, Minnesota), and Summit Medical (Salt Lake City, Utah); has received honoraria for teaching perineural infusion workshops for Kimberly-Clark (Irving, Texas), an infusion pump manufacturer; and has acted as a consultant for Pacira Pharmaceuticals (Parsippany, New Jersey), manufacturer of a long-acting local anesthetic. Dr. Hadzic has consulted and advised for Skypharma (London, England), General Electric (Fairfield, Connecticut), Sonosite (Bothell, Washington), Codman & Shurtleff, Inc. (Johnson and Johnson; Raynham, Massachusetts), BBraun Medical (Bethlehem, Pennsylvania); Cadence Pharmaceuticals (San Diego, California), Pacira Pharmaceauticals (Parsippany, New Jersey), and Baxter International Healthcare, among others. His recent industry-sponsored research includes Glaxo Smith-Kline Industries (London, England), Pacira Pharmaceuticals, and Baxter International Healthcare. Dr. Hadzic is an equity holder at Macosta Medical USA (Needham, Massachusetts), a U.S.-based intellectual property firm. Macosta Medical USA is a patent assignee for an injection pressure monitor. These companies had no input into any aspect of article conceptualization or preparation.


Copyright © 2013, the American Society of Anesthesiologists, Inc. Lippincott Williams & Wilkins. Anesthesiology 2013;118:248-50

should hypothetically block only the branch to vastus medialis, sparing the function to the rest of the quadriceps muscle.

Indeed, in a randomized, double-masked, placebo-controlled trial, repeated boluses of ropivacaine via a perineural catheter inserted into the adductor canal resulted in less dynamic pain and morphine consumption compared with saline boluses in patients with knee arthroplasty. Importantly, subjects receiving boluses of ropivacaine in the adductor canal demonstrated improved ambulation after 24 h, although the factors leading to this improvement remain unknown.

The study published in this issue of ANESTHESIOLOGY by Jæger et al. provides new information that may have potentially significant ramifications for walking the tightrope of optimizing analgesia while retaining quadriceps strength after major knee surgery. Eleven healthy volunteers received either bilateral femoral or adductor canal single-injection nerve blocks (30 ml each), one with ropivacaine (0.1%) and the other with saline, administered in a randomized, double-masked fashion. On a subsequent day after block resolution, the subjects received the alternative/crossover peripheral nerve block (femoral or adductor canal), again with one side receiving ropivacaine and the other saline. Compared with baseline values, the adductor canal block reduced quadriceps muscle strength by 8%, versus 49% for the femoral nerve block. Of note, an 8% reduction with the adductor canal block is probably clinically irrelevant, given that a 10% side-to-side strength difference is common, yet functionally unnoticeable in healthy individuals. Equally noteworthy, the femoral nerve block resulted in decreased ambulation ability relative to the adductor canal block.

We applaud the important documentation by Jæger et al. of quadriceps preservation achieved with adductor canal block. However, we should avoid the temptation to overinterpret the data from healthy volunteers, and conclude that compared with a femoral nerve block, the adductor canal block is a superior technique to provide postoperative analgesia after knee arthroplasty. This study does not provide information on the relative postoperative analgesia imparted by these two approaches. Therefore, it is best viewed as producing data highlighting the reason (minimizing the motor-to-sensory block ratio) that further investigation is required.

Additional questions remain unanswered, such as the volume of local anesthetic to optimize the analgesic to motor block ratio. For example, 3 of 11 subjects in the study by Jæger et al. experienced more significant quadriceps muscle weakness relative to the remaining volunteers. A previous study documented that an injection of 30 ml fills the entire adductor canal; therefore, any excess volume may track proximally and reach additional nerves/muscle groups. Furthermore, the results of a single-injection adductor canal block cannot be extrapolated to a continuous perineural infusion because pharmacodynamics of local anesthetics vary considerably among anatomic locations and modes of introduction (e.g., single-injection vs. continuous infusion). The previously mentioned randomized, placebo-controlled trial of knee arthroplasty patients receiving repeated adductor canal ropivacaine boluses provides evidence that a catheter technique is superior to no regional anesthetic at all. However, what is now required is a trial directly comparing single-injection and continuous adductor canal and femoral nerve blocks in postsurgical patients.

History is replete with instances of medical “conclusions” based on sound theory, early laboratory evidence, and/or preliminary clinical results, which later proved either misleading or simply incorrect; and, in the interim, patients received suboptimal care. It is therefore imperative that we avoid the temptation to draw conclusions based on incomplete evidence, only to consequently discover our error at the expense of suboptimal analgesia. Therefore, additional clinical research is necessary to determine whether the data reported by Jæger et al. signal a transformation in postknee surgery analgesic management, or, rather, represent an important addition to our understanding of functional regional anesthesia, but without a prodigious impact on clinical practice. The same scrutiny should be applied to an ever-increasing number of technique innovations made possible with ultrasound guidance, but awaiting documentation of both benefits and risks.

Brian M. Ilfeld, M.D., M.S.,* Admir Hadzic, M.D., Ph.D.†

* Department of Anesthesiology, University of California, San Diego, San Diego, California. bilmfeld@ucsd.edu. † College of Physicians and Surgeons, Columbia University, New York, New York.

References
In December of 1884, George B. Snow of Buffalo, New York, filed a patent application for his “inhaler” with its “capillary feeder leading from the [chloroform] reservoir below to the [nitrous oxide] inhaling-tube above”—from B to A in two of the filed diagrams (left). Snow’s filing was granted U.S. Patent No. 312771 in February of 1885, and he assigned patent rights to the Buffalo Dental Manufacturing Company. Within two months that company was advertising Snow’s innovation in the Dental Advertiser as a “Chloroform Mixer for Attachment to Nitrous Oxide Apparatus” (right).

George S. Bause, M.D., M.P.H., Honorary Curator, ASA’s Wood Library-Museum of Anesthesiology, Park Ridge, Illinois, and Clinical Associate Professor, Case Western Reserve University, Cleveland, Ohio. UJYC@aol.com.