CHAPTER 12
ANAESTHESIOLOGY AND INTENSIVE CARE

Anaesthetic and sedative medication may only be administered by medical practitioners trained and experienced in their use.

Sound theoretical and practical training followed by several years of supervised experience in the administration of anaesthetics is essential to develop the skills of the anaesthetist. Even within the recommended dosage range, anaesthetic agents can cause death when inappropriately used and only as a last resort should they be administered by non-specialised personnel. *LoE:III*[i]

Medicines and equipment for resuscitation should be functional and immediately available whenever general anaesthesia, regional anaesthesia or sedation is administered.

The following is a list of medicines required for anaesthesia that should be available at district and regional hospitals.

The doses of the medicines given are those recommended for healthy adults. Patients who are acutely or chronically sick, and or elderly, may require substantial reductions in the doses given otherwise life-threatening adverse effects may ensue.

12.1 PREMEDICATION

- Lorazepam, 1–2 mg, oral, the night before surgery and 1–2 hours preoperatively
  - Use half the dose in the elderly.
  - Duration of action (10–20 hours).
  - Unsuitable for day case surgery.

LoE:III[ii]

- Midazolam, 5–7.5 mg, oral, one hour preoperatively.
  - **Use only in healthy adults <65 years of age.**
  - Duration of action 1–4 hours.
  - Suitable for day case surgery. *LoE:III*[iii]

12.2 ANAESTHESIA, GENERAL

12.2.1 INTRAVENOUS INDUCTION (AND/OR MAINTENANCE) AGENTS

Inject intravenous induction agents over 30 seconds (>60 seconds in the elderly).
Titrate the dose to effect.

Respiratory depression occurs following induction of anaesthesia and ventilation should be supported as required.
Administer at appropriate doses, after consideration of patient factors, surgical factors and contraindications:

» Propofol is the most widely used IV induction agent but can produce hypotension.
» Etomidate or ketamine is preferred in haemodynamically unstable patients.
» Thiopental has a rapid onset, is contraindicated in porphyria and may be preferred for Caesarean deliveries. *LoE:III*[iv]

- Propofol, IV, 1.5–2.5 mg/kg.
  - 6–12 mg/kg/hour IV infusion for maintenance, if volatile agent use contraindicated.
- Etomidate, IV, 0.3 mg/kg (0.2–0.6 mg/kg)
- Ketamine, IV, 1–2 mg/kg.
- Thiopental, IV, 3–5 mg/kg.

12.2.2 INHALATION AGENTS

12.2.2.1 INDUCTION

In adults, intravenous induction is preferable.
Inhalational induction is reserved for patients with difficult airways or severe needle phobia.
Use only halothane or sevoflurane (isoflurane is too irritant). Halothane can cause hepatitis after repeated exposure within 3 months. Halothane sensitises the heart to catecholamines and may cause cardiac dysrhythmias, particularly if anaesthesia is too light or the patient hypercarbic.
Sevoflurane is not associated with these problems, has a faster onset and emergence time.

- Halothane, titrated to effect.

OR

- Sevoflurane, titrated to effect. *LoE:III*[v]

12.2.2.2 MAINTENANCE

In spontaneously breathing patients, the dose of a volatile agent is titrated to clinical effect. If a neuromuscular blocking agent has been used, the dose of the volatile agents must be adequate to prevent awareness. This is about 1 minimum alveolar concentration (MAC), but must be titrated according to clinical signs of awareness (e.g. tachycardia, hypertension, sweating, lacrimation).

- Isoflurane (MAC = 1.2%).

12.3 MUSCLE RELAXANTS

Used to facilitate intubation and to provide intraoperative muscle relaxation for surgery. It must not be used if difficult intubation anticipated.

12.3.1 DEPOLARISING MUSCLE RELAXANTS

- Suxamethonium, IV, 1–1.5 mg/kg.
  - Onset 30–60 seconds.
  - Duration 5 minutes.
  - Repeated doses associated with bradycardia and prolonged neuromuscular block.
  - Contraindicated in patients at risk for developing suxamethonium-induced hyperkalaemia, e.g. upper or lower motor neuron defect, prolonged chemical denervation (ICU >3 days), direct muscle trauma, tumour or inflammation, burns, disuse atrophy, severe infection, pre-existing hyperkalaemia.

LoE:III[vi]

12.3.2 NON-DEPOLARISING MUSCLE RELAXANTS (NDMR)

Use a nerve stimulator to monitor effect and determine when subsequent doses (about a fifth of the intubating dose) are required.

Higher doses result in shorter onset times but longer duration of action.

- Intermediate-acting neuromuscular blocking agents, e.g.:
- Cisatracurium (shorter-acting) *LoE:III*[vii]
  - Intubation dose 0.1–0.15 mg/kg.
  - Onset 3–5 minutes.
  - Duration of action 45–55 minutes.
  - Eliminated by Hoffman degradation, therefore can be used in renal or liver impairment.
- Vecuronium
  - Intubation dose 0.08–0.1 mg/kg.
  - Intubate after 2 minutes. *LoE:III*[viii]
  - Duration 20–30 minutes.
  - Eliminated by liver and kidney: avoid in renal and liver impairment.

12.3.3 MUSCLE RELAXATION FOR RAPID SEQUENCE INTUBATION

Patients at risk of aspiration (e.g. emergency surgery, incomplete gastric emptying) require a rapid sequence intubation.
An IV induction agent is given through an IV line with fast running fluids, immediately followed by a rapidly acting muscle relaxant.
Cricoid pressure is applied and then intubation proceeds.
The rapid onset of action enables the time to intubation to be short enough to avoid mask ventilation, as this can result in gastric insufflation and aspiration of gastric contents.

- Suxamethonium, 1–1.5 mg/kg, IV. (See section 12.3.1: Depolarising muscle relaxants).
  - Preferred agent as, in the event of a failed intubation, it wears off quickly enabling spontaneous respiration to resume.
  - Contraindications to suxamethonium
    - Congenital and acquired medical conditions associated with severe, potentially lethal suxamethonium-induced hyperkalaemia.
    - Malignant hyperthermia. *LoE:I*[ix]

If suxamethonium is contra-indicated, consider:

- Rocuronium, 0.9 mg/kg, IV.
  - Duration +/- 60 minutes. *LoE:III*[x]

Sub-optimal conditions for intubating and prolonged effect can be problematic in the event of a difficult or failed intubation and if the procedure is short.

12.3.4 MEDICINES TO REVERSE MUSCLE RELAXATION

Only administer when the clinical signs of NDMR are wearing off or at least 2 twitches occur using train-of-four on nerve stimulator.

Neostigmine has profound cholinergic effects and, to counteract resultant profound bradycardia, is administered mixed with an anticholinergic agent, atropine or glycopyrrolate.

Whilst atropine is effective and can be used for this purpose in otherwise healthy patients, the onset of neostigmine and duration of action more closely matches that of glycopyrrolate, so this is the preferred combination agent for patients who poorly tolerate tachycardia or bradycardia.

- Neostigmine, IV, 50 mcg/kg. *LoE:III*[xi]

WITH EITHER:

- Atropine, IV, 20 mcg/kg (maximum 1.2 mg).

OR *LoE:III*[xii]

Glycopyrrolate, IV, 10 mcg/kg.

LoE:III[xiii]

12.4 PERIOPERATIVE ANALGESIA

R52.9

» The perioperative period includes the preoperative, intraoperative and post-operative stages of surgery.
» Perioperative analgesia should be multi-modal, i.e. use analgesics, where possible, from different classes to reduce side effects from high doses of a single agent (e.g. paracetamol, NSAID and a weak/strong opioid) with either a regional block or wound infiltration with local anaesthetic.
» Patients with pain before surgery should be given analgesia preoperatively.
» Paracetamol may be given orally with premedication to prophylactically reduce perioperative pain.
» Intraoperatively, analgesics are given intravenously and/or a central neuraxial or regional local anaesthetic block may be used. The analgesic effect of these may extend into the early postoperative period.
» Postoperatively analgesics are given IV, IM and/or rectally, until the patient is able to take oral medication. Patients with a functioning block may not require analgesia until the block wears off but analgesics should be prescribed in anticipation of this.
» Pain severity should be assessed frequently post-operatively (see Section 12.5.3: Postoperative analgesia ward prescriptions).

12.4.1 PERIOPERATIVE ANALGESICS

12.4.1.1 ORAL ANALGESICS

- Paracetamol, oral, 1 g 4–6 hourly when required.
  - Maximum dose: 15 mg/kg/dose.
  - Maximum daily dose: 4 g in 24 hours.

AND

LoE:I[xiv]

- Tramadol, oral, 50–100 mg 4–6 hourly.
  - Avoid in head injury and epilepsy.
  - Improved effect when given with paracetamol.

AND

LoE:III[xv]

- NSAID, e.g.:
- Ibuprofen, oral, 400 mg 8 hourly with meals.

Note: Do not administer NSAIDs to patients at risk of hypovolaemia, renal impairment or gastrointestinal bleeding. Avoid in patients with asthma who experience bronchospasm with NSAIDs.

LoE:III[xvi]

12.4.1.2 INTRAVENOUS ANALGESICS

- Fentanyl, IV, 1–2 mcg/kg
  - Onset ± 3 minutes, duration of action 30–60 minutes. Higher doses last longer. LoE:III[xvii]

- Morphine, IV/IM, 3–5 mg as a single dose then further boluses at intervals of 5–10 minutes and monitor all vitals closely. LoE:III[xviii]
  - Dilute 10 mg up to 10 mL with sodium chloride 0.9%.
  - Total maximum dose: 10 mg.
  - Repeat after 4 hours if necessary.
  - Monitor response to pain and effects on respiration and BP.
  - Onset 5-10 minutes. Duration of action ± 3 hours.
  - Histamine release may cause intraoperative hypotension.

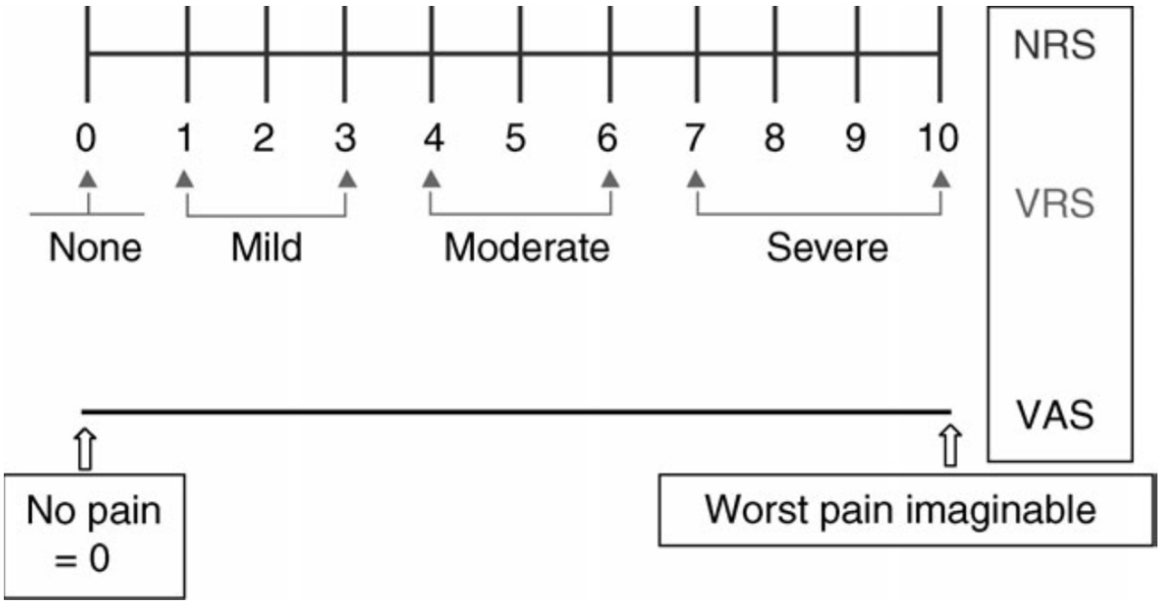
- Ketamine, IV, 0.1–0.3 mg/kg – a subanaesthetic dose given pre-incision may reduce persistent post-surgical pain. LoE:I[xix]

12.4.2 POSTOPERATIVE PAIN IN THE RECOVERY ROOM

R52.0

Pain should be assessed on arrival in the recovery room and at regular intervals postoperatively. Pain Scores should be recorded with other routine postoperative observations.

A Numeric Rating Scale (NRS) can be used to score pain:



Source: Breivik H, Borchgrevink PC, Allen SM, Rosseland LA, Romundstad L, Hals EK, Kvarstein G, Stubhaug A. Assessment of pain. *Br J Anaesth.* 2008 Jul;101(1):17-24.

The patient is asked to indicate on the scale the numeric value that best indicates their pain intensity or verbally if they cannot visualise the scale.

Severe pain (use lower doses if pain less):

- Morphine, IV, to a total maximum dose of 10 mg (See Appendix II, for individual dosing and monitoring for response and toxicity).
  - Monitor conscious level and pulse oximetry continuously. Also monitor respiration, heart rate and BP at 5 minute intervals and for at least 20 minutes after the last IV morphine bolus.

In patients at high risk for respiratory depression, tramadol may be used instead of morphine as it causes less respiratory depression (although respiratory depression may still occur with tramadol).

Tramadol is a weak opioid agonist and increases spinal cord levels of serotonin and noradrenaline.

- Tramadol, IV, 50–100 mg over 3 minutes to reduce side-effects of nausea and vomiting (Specialist prescribed).
  - Ceiling effect i.e. higher doses do not improve pain relief. *LoE:III*[xx]

In addition to morphine or tramadol, diclofenac may also be given to supplement analgesia and reduce opioid requirements:

- Diclofenac, **deep IM**, 75 mg 12 hourly.
  - Administer for a maximum of 2 days.
  - Avoid the same injection site.
  - Counsel patient prior to injection of adverse events (scarring) at inject site, if applicable. *LoE:III*[xxi]

12.4.3 POSTOPERATIVE ANALGESIA WARD PRESCRIPTIONS

Analgesia should be prescribed according to the severity of pain anticipated from the surgery and the anticipated, appropriate, postoperative route of administration.

Pain should be assessed at regular intervals on the ward postoperatively. Pain scores should be recorded with other routine postoperative observations.

Respiratory rate should be monitored for opioid-induced respiratory depression.

12.4.3.1 EXAMPLES OF WARD PRESCRIPTIONS FOR POSTOPERATIVE ANALGESIA ACCORDING TO ANTICIPATED PAIN SEVERITY

R52.9

MILD PAIN:

- Paracetamol, oral, 1 g 4–6 hourly when required.

- Maximum dose: 15 mg/kg/dose.
- Maximum daily dose: 4 g in 24 hours.

AND

- NSAID, oral, e.g.:
- Ibuprofen, oral, 400 mg 8 hourly after meals.

CAUTION

Concomitant use of more than one oral NSAID has no additional clinical benefit and only increases toxicity.

Use of all NSAIDs is associated with increased risks of gastrointestinal bleeding, renal dysfunction, and cardiovascular events (stroke and myocardial infarction).

NSAIDs should be used judiciously at the lowest effective dose for the shortest duration. Explore and manage exacerbating factors for pain. See section 26.1: Chronic pain.

Do not use NSAID in pregnancy or while breastfeeding.

AND

- Tramadol, oral, 50–100 mg 4–6 hourly.
  - Avoid in head injury and epilepsy.
  - Improved effect when given with paracetamol.

MODERATE PAIN:

- Paracetamol, oral, 1 g 4–6 hourly when required.
  - Maximum dose: 15 mg/kg/dose.
  - Maximum daily dose: 4 g in 24 hours.

AND

- NSAID, oral, e.g.:
- Ibuprofen, oral, 400 mg 8 hourly with meals.

CAUTION

Concomitant use of more than one oral NSAID has no additional clinical benefit and only increases toxicity.

Use of all NSAIDs is associated with increased risks of gastrointestinal bleeding, renal dysfunction, and cardiovascular events (stroke and myocardial infarction).

NSAIDs should be used judiciously at the lowest effective dose for the shortest duration. Explore and manage exacerbating factors for pain. See section 26.1: Chronic pain.

Do not use NSAID in pregnancy or while breastfeeding.

AND

- Tramadol, oral, 50–100 mg 4–6 hourly.
  - Avoid in head injury and epilepsy.
  - Improved effect when given with paracetamol.

OR

Morphine, IM, 0.1–0.2 mg/kg 4 hourly or IV via a patientcontrolled analgesia device (see below).

SEVERE PAIN:

- Morphine, IM, 0.1–0.2 mg/kg 4 hourly or IV via a PCA device.

AND

- Paracetamol, oral, 1 g 4–6 hourly when required.
  - Maximum dose: 15 mg/kg/dose.
  - Maximum daily dose: 4 g in 24 hours.

AND

- NSAID, e.g.:
- Ibuprofen, oral, 400 mg 8 hourly with meals.

LoE:III[xxii]

Note:

Patient controlled analgesia

If a device is available that will administer patient controlled analgesia:

- Morphine, IV, in boluses of 1 mg every 6-10 minutes, with a maximum dose of 0.1–0.2 mg/kg 4 hourly.
  - In the elderly and frail, the dose of morphine should be reduced and the dosage interval increased.

LoE:I[xxiii]

If unable to take oral medication, stop oral ibuprofen and use:

- Diclofenac, **deep IM**, 75 mg 12 hourly, to upper, outer quadrant of buttock.
  - Administer for a maximum of 2 days.
  - Avoid the same injection site.
  - Counsel patient prior to injection of adverse events (scarring) at injection site if applicable.

LoE:III[xxiv]	

12.5 INTRAVENOUS FLUIDS

The following IV fluids should be available for perioperative fluid replacement and maintenance therapy.

12.5.1 CRYSTALLOIDS

Most commonly used crystalloid for perioperative fluid maintenance:

- Sodium chloride 0.9%, IV.

Higher sodium content than indicated if there is a perioperative risk of hyponatraemia e.g. transurethral resection of prostate.
Balanced solutions may be appropriate in some patients (i.e. presentation with hyponatraemia, previous renal placement therapy):

- Balanced solution, e.g.:
- Ringer Lactate, IV.

LoE:I[xxv]

12.6 MEDICINES TO TREAT COMPLICATIONS OF ANAESTHESIA

12.6.1 MALIGNANT HYPERTHERMIA

T88.3

- Dantrolene IV, 2.5 mg/kg as a single dose (preferably through large bore cannula).
  - Reconstitute with 60 mL water for injection. For a 70 kg patient, 175 mg (9 vials) is required.
  - Administer subsequent doses to clinical effect (cardiac and respiratory symptoms stabilise, muscle tone and body temperature reduced).
  - Doses higher than 10 mg/kg is uncommon and the clinician should question the diagnosis.
  - Although, high doses of 10 mg/kg may be required in muscular males.

LoE:III[xxvi]

12.6.2 LOCAL ANAESTHETIC TOXICITY

T41.3

Airway management:

- Ventilate with 100% oxygen.

Seizure suppression:

- Diazepam, IV, 10 mg.

Cardiopulmonary resuscitation may be required:

- Reduce individual adrenaline (epinephrine) doses to <1 mcg/kg.

LoE:III[xxvii]

- Lipid emulsion (20%), IV, 1.5 mL/kg over 1 minute, then continuous infusion 0.25 mL/kg/minute.
  - Repeat bolus 1–2 times for persistent cardiovascular collapse.
  - Double infusion rate to 0.5 mL/kg/minute if BP remains low.
  - Continue infusion for at least 10 minutes after cardiovascular stability attained.
  - Recommended upper limit: approximately 10 mL/kg lipid emulsion over the first 30 minutes.

LoE:III[xxviii]

12.6.3 ANAESTHETIC-RELATED ACUTE HYPOTENSION

I95.81

Treat the cause of hypotension.
Ensure appropriate fluids are given to correct hypovolaemia.
The medicines given below all require significant dilution before administration.

- Adrenergic and dopaminergic agents, e.g.:
- Ephedrine IV, 3–5 mg as a single dose and then further boluses as required to a maximum of 30 mg.
  - Increases heart rate and contractility, and vasoconstrictor.
  - Repeated administration can result in tolerance and tachyphylaxis.
  - Alternative vasopressor infusion (e.g. adrenaline (epinephrine)) may be needed to mitigate unresponsiveness to treatment.

LoE:III[xxix]

OR

Phenylephrine IV, 50–100 mcg as a single dose and then infuse at 60–180 mcg/minute.

- Vasoconstrictor. *LoE:III*[xxx]
- High doses may cause significant reflex. bradycardia: treat this by discontinuing the phenylephrine only.

12.6.4 ANAESTHETIC-RELATED ACUTE HYPERTENSION

I97.3

To obtund the hypertensive response to intubation e.g. pre-eclampsia:

- Alfentanil, IV, 7.5 mcg/kg (with magnesium sulfate, IV 30 mg/kg).

LoE:III

During anaesthesia or post-operatively, establish the cause (e.g. light anaesthesia or inadequate pain relief) and treat as appropriate.

- Labetalol IV, 5–10mg IV over 2 minutes.
  - Repeated at intervals of at least 5 minutes to maximum 200 mg.
  - Duration of action 50 minutes.
  - Vasodilates and slows heart rate. *LoE:III*[xxxi]

12.6.5 POSTOPERATIVE NAUSEA AND VOMITING (PONV)

12.6.5.1 PREVENTION OF PONV

R11.2

Patients identified preoperatively as medium or high risk for PONV should be considered for prophylactic antiemetics.
Prophylactic antiemetics also required if postoperative vomiting is potentially dangerous, e.g. after jaws wired, open eye surgery, oesophageal surgery.

High risk patients should receive anti-emetics from ≥ 1 class.
Adequate IV hydration associated with less PONV.

Risk factors for PONV	Points
Female Gender	1
Non-Smoker	1
History of PONV and/or motion sickness	1
Postoperative opioids	1
Sum	0–4

Points	Risk for PONV (%)	Risk category
0	10	Low
1	20	Low
2	40	Medium
3	60	High
4	80	High

Class	Anti-emetic	Prophylactic Dose and timing	Notes
Corticosteroid (glucorticoids)	e.g.: Dexamethasone	4-8 mg, IV, on induction. *LoE:II*[xxxii]	Increases blood glucose in diabetics. Only used for prophylaxis, not established PONV.
5-HT_3 receptor antagonist	e.g.: Ondansetron	4–8 mg, slow IV/IM, on induction. *LoE:III*[xxxiii]	Prolongs QTc interval
Phenothiazine	Promethazine	6.25–12.5 mg, IV (large bore cannula) diluted to 20 mL over 10-20 minutes, or deep IM, at end of surgery.	Intra-arterial injection causes gangrene. Extravasation or subcutaneous injection associated with skin necrosis. Anticholinergic side effects and sedation.

12.6.5.2 TREATMENT OF PONV

R11.2

Ensure adequate hydration and correct hypotension if present.
Give an emetic from a different class than the prophylactic agent given (except dexamethasone, which is only used for prophylaxis).

- Metoclopramide, IM/IV
  - If <60 kg: 5 mg IM or IV (over 2 minutes).
  - If ≥60 kg: 10 mg IM or IV (over 2 minutes).
  - Repeat 8 hourly if required.

Note: Metoclopramide can cause extrapyramidal side effects.

Treat acute dystonic reactions with:

- Anticholinergic agent, e.g.:
- Biperiden, IM/IV, 2 mg.
  - Repeat as necessary.

If an anticholinergic agent is not available:

- Promethazine, deep IM, 25–50 mg.
  - In the elderly 25 mg.

If an anticholinergic agent or promethazine is not available:

- Diazepam, IV, 5–10 mg for symptom relief. *LoE:III*

12.6.6 ACID ASPIRATION PROPHYLAXIS

O74.0

The use of a non-particulate, non-effervescent antacid reduces the risk of pneumonitis if gastric fluid is aspirated. Give to patients at risk of aspiration, e.g. pregnant women before Caesarean delivery.

- Sodium citrate, 0.3M, oral, 30 mL.
  - Not more than 30 minutes pre-induction of anaesthesia.

LoE:I[xxxiv]

12.7 ANAESTHESIA, SPINAL (INTRATHECAL)

Only preservative free medicines may be used.
Larger doses cause block to spread higher, with risks of respiratory depression, hypotension and loss of consciousness.

- Bupivacaine 0.5% (Spinal use)
  - Give up to 3 mL according to desired level of block.
  - Becomes hypobaric (light) within CSF so block may spread higher than anticipated.

- Bupivacaine 0.5% with dextrose (Spinal use)
  - Give up to 3 mL according to desired level of block.
  - Hyperbaric (heavy) so block spreads according to patient position.

To increase duration of analgesia:

ADD

- Fentanyl, 10–25 mcg (i.e. small amounts).

Caesarean deliveries
Lower doses are required due to physiologic changes of pregnancy:

- Bupivacaine 0,5% with dextrose, 1.8 mL (9 mg).

AND

- Fentanyl, 10 mcg (0.2 mL).

12.7.1 ANTICOAGULANTS AND SPINAL OR EPIDURAL BLOCKS

Patients on anticoagulants are at risk of developing a spinal haematoma with subsequent paralysis after a spinal or epidural block. These anticoagulants should be stopped before the spinal or epidural is performed according to the guidelines given below. In order to encourage safe and quality care of patients, **please consult a specialist prior to attempting blocks on patients on anticoagulants**. There are a range of oral anticoagulation, with each having specific recommendations with regard to neuraxial blocks.

Timing of anticoagulants in patients receiving neuraxial anaesthesia:

Anticoagulant	Before Neuraxial Block	After Neuraxial block
Warfarin, oral	Consult with specialist to stop warfarin.	Restart after neuraxial block performed (do not delay) and epidural catheter removed. Monitor INR daily with indwelling catheter.
Unfractionated Heparin, SC	Neuraxial techniques may be performed if total daily dose is <10 000U. Check PTT if higher doses are used.	
Unfractionated Heparin, IV	Stop heparin 4-6 hours and check PTT<40	Wait 1 hour before next bolus/infusion restarted.
Prophylactic LMWH, SC	12 hours after last dose	4 hours after neuraxial block performed and epidural catheter removed
Therapeutic LMWH, SC	24 hours after last dose	>24 hours *and* consult a specialist (bleeding risk of surgery should be assessed).

LoE:II[xxxv]

Note. After neuraxial block or epidural catheter removal, patients should be observed closely for new or progressive neurological symptoms. A spinal haematoma can result in permanent paralysis unless decompressive surgery is performed within 8 hours of paralysis onset.

Clopidogrel and platelet GPIIb/IIIa inhibitors have variable durations of effects on clotting after stopping these medications. Specialist advice should be

sought before performing neuraxial blocks on patients receiving these medications.

For patients on warfarin the use of bridging anticoagulation (giving heparin after warfarin is stopped in preparation for surgery or invasive procedures) remains unsettled. Practitioners should exercise careful judgment of competing risks in individual patients. Heparin may increase the risk of bleeding. Whatever practice is adopted the most important consideration is to ensure that adequate anticoagulation with warfarin is re-instituted once the risk of bleeding is past.

12.8 ANAESTHESIA, EPIDURAL

Only preservative free medicines may be used.
Local anaesthetics are administered through a catheter inserted into the epidural space at a spinal level appropriate for the surgery.
Aspiration and a test dose (2–3 mL) of local anaesthetic should be given to confirm catheter not intravascular or intrathecal. Subsequent doses should be fractionated (3–5 mL boluses).

- Bupivacaine 0.5%.
  - Onset ±10 minutes.
  - Duration ±4 hours.
  - Motor block is less with lower concentrations.
  - Maximum dose 2 mg/kg.

LoE:III[xxxvi]

12.9 PERIPHERAL NERVE BLOCK OR WOUND INFILTRATION

Only preservative free medicines may be used for nerve blocks.
Lidocaine has a faster onset of action than bupivacaine, but a shorter duration of action.

- Lidocaine 1% or 2%.
  - Higher concentrations cause more pain on injection.
  - Maximum dose: 3 mg/kg.
- Lidocaine 2% plus adrenaline.
  - Not to be used in areas supplied by an end-artery e.g. finger, ear, penis.
  - Maximum dose: 7 mg/kg.
- Bupivacaine 0.5%
  - Not be used in mucosal areas as risk of systemic toxicity.
  - Maximum dose: 2 mg/kg.

LoE:III[xxxvii]

12.10 ANAESTHESIA, TOPICAL

- Lidocaine jelly, topical, 2 g/100mL.
  - For urethral catheterisation: female 5–7 mL, male 10–15 mL.

LoE:III[xxxviii]

- Lidocaine topical spray, 4%.
  - Maximum dose 160 mg.
  - To assist with awake intubation or reduce haemodynamic response to intubation.

LoE:III[xxxix]

For venepuncture analgesia in adults or oncology patients requiring repeated invasive procedures (e.g. lumbar punctures, venepuncture):

- Lidocaine/prilocaine, topical cream, 2.5/2.5%.
  - Apply at least 1 hour before and cover with occlusive dressing.

LoE:III[xl]

12.11 SEDATION

See chapter 23: Sedation.

12.12 PAIN, CHRONIC

See chapter 26: Pain.

12.13 INTENSIVE CARE

12.13.1 NUTRITIONAL SUPPORT

E63.9

Establish a multidisciplinary nutrition support team to assess and address the nutritional requirements of patients. This team should include a dietician.

Nutrition support should be considered in patients at risk, defined as those who have a poor absorptive capacity and/or high nutrient losses and/or increased nutritional needs from causes such as catabolism.

Oral feeding, if feasible, is preferred.
Enteral tube feeding is the next best option.
Total parenteral nutrition (TPN) is indicated in exceptional circumstances.
For short-term care (≤ two weeks), the current standard formulas in multi-chamber bags that have a long shelf-life are considered to provide adequate nutritional support. Clinicians should be aware of the possibility of clinically important hypovitaminosis in individual patients, and replace selected vitamins where appropriate.

Refer to the most current version of the National Department of Health Parenteral Nutrition Practice Guidelines for Adults, available at: www.health.gov.za

In selecting the treatment modality, the team should consider:
» The likely duration of nutrition support.
» Patient activity levels and the underlying clinical condition, e.g. catabolism.
» Gastrointestinal tolerance, potential metabolic instability and risks of re-feeding.

Potential complications harms of nutritional support include:
» Re-feeding syndrome: Hypophosphataemia occurs when patients are re-fed too quickly with high carbohydrate feeds. The syndrome usually begins within 4 days of re-feeding. A multitude of life-threatening complications involving multiple organs may occur, causing: respiratory failure, cardiac failure, cardiac dyshythmias, rhabdomyolysis, seizures, coma, red cell and leukocyte dysfunction. The most effective way to prevent re-feeding syndrome is that feeds should be started slowly with aggressive supplementation of magnesium, phosphate and potassium.
» Diarrhoea.
» Lactose intolerance.

Regularly review the need for ongoing therapeutic nutritional support.

Vitamin and mineral supplementation should be considered on a case-by-case basis.

Enteral tube feeding
Enteral tube feeding should be used in patients who cannot swallow or who are at risk of aspiration.
Patients should be fed via a nasogastric tube unless this is contra-indicated.
Patients with upper gastro-intestinal dysfunction (or an inaccessible upper gastro-intestinal tract) should receive post-pyloric (duodenal or jejunal) feeding.
Percutaneous endoscopic gastrostomy feeding should be used in patients likely to need long-term (≥4 weeks) enteral tube feeding.

Parenteral feeding
The team should consider parenteral nutrition in patients who are malnourished or at risk of malnutrition and fit the following criteria:
» inadequate or unsafe oral and enteral tube nutritional intake, or
» a non-functional, inaccessible or perforated (leaking) gastrointestinal tract.

Note: For short-term care, the current standard formulas in multi-chamber bags that have a long shelf-life are considered to provide adequate nutritional support.

The addition of glutamine does not confer any clear clinical benefits and is thus not recommended.

Parenteral nutrition can be withdrawn once adequate oral or enteral nutrition is tolerated and nutritional status is stable. Withdrawal should be planned and done in a stepwise way with a daily review of the patient's progress.

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