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Editorial I

Time to Standardize Regional Anaesthesia Blocks: An International Effort for a Good Cause

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During the last 10 years we have seen an explosion of novel nerve blocks based on different ways of describing either anatomical targets, fascial planes or local anaesthetic distributions. The introduction of ultrasound machines in regional anesthesia had a major impact factor in this. To put our readers in perspective more than 100 published blocks have been developed during this time. Very wisely, a group of sixty international recognized experts in the field of regional anaesthesia embarked in a project to reach a consensus on this matter. These could be useful for educating or researching the new generation of interventional pain and regional anaesthetists.

The project called international Delphi consensus study on its first publication concentrated on abdominal, paraspinal and chest thoracic wall blocks. This is based on the popularity of these novel blocks when we look at publications in the recent years.

The conclusion of the Delphi paper stated a strong consensus for the majority of block approaches. The following are some examples of this:

The posterior TAP and the lateral quadratus lumborum blocks were unified into the latter. For the paraspinal blocks there was a weak or no consensus so it will require more time for this.

The rhomboid intercostal plane block achieved strong consensus for the anatomical description only but this was not the case for the serratus plane block. Equally the PECS block did not achieve strong consensus into changing to inter pectoral plane block so will be discretionary for the time being. The same applies to the PECS II block into pecto-serratus block, will be discretionary based on weak consensus.

Finally, there was a strong consensus that the superficial, deep, or muscle-related planes composed of connective tissue should be called fascial planes rather than interfascial planes applying only in reference to anatomical descriptions.

It is very important to address that this publication is the first of this kind and may be prone to bias and different answers, depending on the way the questions were formulated but it is an starting point. It aims to see the real impact over the coming years in the field. Simple, clear and descriptive approaches should be the three pillars to be used in regional anaesthesia, the same as the three pillars that resume a good standard of care: education, research and clinical application. This year 2022 we will hopefully see published a second round on the matter, this time involving upper and lower limb blocks so we are optimistic in terms of a new era in regional anaesthesia.

It is undeniable that we are living a time of immense popularity of regional anaesthesia specialty and we must not lose momentum to build recognition of the work well done. We have brought back the importance of basic medical subjects like anatomy, attracting interest within the anaesthesiologist. We want our specialty to make sense and provide clear evidence of why we need to block and why the idea of "no patient without a block" or a "multimodal approach" is our goal. Regional anaesthesiologist are highly skill doctors, with invaluable hands-on skills. Our colleagues know that and we should be proud of that. Other fields that are closely connected like chronic pain interventional medicine should be reviewed in the years to come and perhaps by them we could also address nomenclature and the technique effectiveness.

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As part of this editorial, we would like to encourage our readers to work together in this direction, continue researching and sharing their expertise, their findings, for the benefit of our global community. Reevaluation will also be needed as some of the names in previous published article has gained popularity and most probably will be difficult to revert.

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References

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