



Editor's Note

I remember as a kid watching the musical movie "Oklahoma" and even learning to sing some of the songs like "Oh what a beautiful morning" etc. The musical is set in an Oklahoma, of course, farming community in the 1800's. One young man had been on a trip to Oklahoma City and in the one song he sang about how technologically advanced it was there compared to them. In the chorus he sings, "Yes, they've gone about as far as they can go!".

Which makes me think. Have we not "gone as far as we can go" with regional anaesthesia in South Africa, or are we not fast approaching that point?

Why? Well in the past eight years or so we have seen the interest in regional anaesthesia soar in South Africa. BUT I think this is as far as we will go UNLESS we change a few things.

At the moment, I think, we are fast approaching the point where everyone who wants to and who can do regional anaesthesia is doing it, but sadly we still lag far, very far, behind other developed countries, which our private medicine is proud to be part of, largely. Which is sad, because in a developing country regional anaesthesia should predominate especially in rural areas and state and teaching hospitals. How can we get more people to want to do it and to know how to do it?

When presenting workshops and lectures etc it almost always comes out that anaesthesiologists would like to do more regional anaesthesia – either for surgery OR for post-op pain management, but that they experience resistance from their surgeons.

The resistance to regional anaesthesia from surgeons has a three-fold origin.

IGNORANCE. Most surgeons in our country have been "raised" without exposure to regional anaesthesia. When the older generation trained regional was not an issue so they do not know it. The younger surgeons are still being raised without proper exposure to regional anaesthesia and they also do not know it. I must add that usually when

they are exposed to regional anaesthesia and it's advantages – to themselves and their patients, they 'convert' with alacrity and start expecting it from their anaesthesiologists.

So ignorance on the part of the surgeons plays a huge role, BUT are we as anaesthesiologist not responsible for their ignorance? It is after all we who are not exposing these surgeons to regional anaesthesia while they are training in the academic institutions. It is my opinion that regional anaesthesia is still very much the "orphan" in academic institutions with nobody taking care of it there. Formal regional anaesthesia is rudimentary as best in most institutions with one or two possible exceptions. Regional anaesthesia is not even a great feature, if at all, in the examinations for either the FFA or the MMed. Most of the regional anaesthesia is taught and learned post qualification – being taught and promoted by a small group of enthusiasts who are trying to bring our anaesthetic practice in line with the rest of the world, especially Europe - who are the undisputed leaders in regional anaesthesia.

Until regional anaesthesia is given the attention it deserves in academic institutions in keeping with world wide practice, and the surgeons are not exposed to it and its benefits while in training we will continue to experience the resistance from surgeons and we will soon "have gone as far as we can go".

TIME CONSTRAINTS. On theatre lists in private practice, time is the huge consideration. Some of the resistance from the surgeons stems from this. They feel that regional anaesthesia wastes time or at least takes too long and prolongs the list. Surgeons have accused anaesthesiologist who want to practice regional anaesthesia of "playing" or "experimenting on my patients" and that there is no time for this nonsense. We cannot blame the surgeons, as WE have not informed them. If he were a "convert" he would be willing to wait for good (see below) regional anaesthesia and would book his list accordingly – making allowances for it. Please note, that there are surgeons who do this – not all of them are uninformed. Those that are informed were usually informed by anaesthesiol-

ogist in private practice and have learned about it there. The solution to this problem is to expose surgeons to good (see below, again) regional anaesthesia in training so that they will expect it in practice and would make allowances for it in private practice.

GOOD REGIONAL ANAESTHESIA. Perhaps the surgeon's perception that regional anaesthesia is playing and a waste of time is not unwarranted. If an anaesthesiologist dabbles, and I use the word advisedly, in regional anaesthesia without having received any training theoretical or practical and he is in general not too sure of what he doing he will take too long to do blocks and then they may not work properly if at all eliciting the remark from the surgeon that he is "playing". The onus is once again on US. If we want to promote and further the cause for regional anaesthesia in keeping with the rest of the world then we must produce quality regional anaesthesia.

This brings me, again, to the matter of training. In my opinion our anaesthetic training **MUST** start placing more emphasis on regional anaesthesia and start taking it seriously and seeing it as an important part of any anaesthesiologist's training. We are already being left behind the rest of the world – even Latin America! and if we do not wake up we will, once again, be the tail enders and we will have no one to thank but ourselves.

Even the people already qualified. If we did not receive training on regional anaesthesia then it remains our own responsibility to get ourselves trained and educated in regional anaesthesia. The opportunities abound in the form of workshops offered at congresses and elsewhere. The anaesthetised pig workshops, which we did for years (and still do at a lesser rate), and were in fact pioneered in South Africa, went a long way to bridging the gap. Cadaver workshops and hands-on workshops are held regularly at the anatomy department in Pretoria. Advanced workshops or Regional Anaesthesia for Chronic Pain workshops are held regularly at Little company of Mary Hospital in Pretoria. Durban and Cape Town also hold workshops – there is no excuse.

RAPSA (Regional Anaesthesia and Pain South Africa) was formed with this very aim in mind – to further the interests of regional anaesthesia and the annual RAPSA meeting is a brilliant opportunity to learn regional through lectures and workshops.

We **MUST** up our game in producing quality regional anaesthesia so that our surgeons will be more inclined to share our enthusiasm.

It does my heart good to see how big the interest is in regional as reflected in the number of people who attend workshops. The regional anaesthesia workshops at the annual SASA meeting in Pore Elizabeth earlier this year were all fully subscribed. **BUT** it doesn't help much if we produce people who can do good regional anaesthesia but they have nowhere to practice it because of surgeon resistance.

How can we reduce surgeon resistance?

1. Better attention paid to regional anaesthesia in our academic institutions – and more regional done there to expose surgeons to it.
2. We must improve the quality of the regional we do to convince the surgeons of its benefits and that we know what we are doing and it does not prolong the list because we are slick. In fact, if properly planned, good regional anaesthesia should make a list move more efficiently.
3. We must all take responsibility for our own surgeons and do our best to inform them. We must especially inform them of the advantages of regional for post-op pain management, and the importance thereof, so that they will convert at least to that.
4. RAPSA does its bit by trying to get in to giving lectures on regional anaesthesia at surgical congresses.
5. Negotiating with your surgeon to let you just try some regional. Once they have seen it they very often change their stance vis-à-vis regional.

It is my opinion that unless we address these issues soon and aggressively we will once again be the followers where we could be up there with the leaders. Perhaps we have already resigned ourselves to, once again, being the followers. We do not need to be and I personally will fight to have regional anaesthesia get the recognition it deserves.

If we don't address this we are soon going to be at the point where **"we have gone about as far as we can go"**.

Russell Phillip Raath

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Editor and Publisher - South African Journal of Regional Anaesthesia (SAJRA)

- S4** Naropin® 2 mg/ml Polyamp® (Injection): Each ml of sterile solution for injection contains ropivacaine hydrochloride monohydrate equivalent to ropivacaine hydrochloride 2.0 mg.
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PHARMACOLOGICAL CLASSIFICATION: A. 4 Local anaesthetics
INDICATIONS: Surgical Anaesthesia: Epidural block for surgery, including Caesarean section. Minor nerve block and infiltration anaesthesia. Major nerve block.
 Acute Pain Management: Continuous epidural infusion or intermittent bolus administration e.g. postoperative or labour pain. Minor nerve block and infiltration analgesia.
 Acute Pain Management in Paediatrics: Caudal epidural block. Peripheral nerve block for peri- and postoperative pain management.

CONTRA-INDICATIONS: Hypersensitivity to local anaesthetics of the amide type. Intravenous regional anaesthesia (Bier's block). Obstetric paracervical anaesthesia.
 Local anaesthetics: contra-indicated for epidural and spinal anaesthesia in patients with uncorrected hypotension. Local anaesthetic techniques must not be used when there is inflammation and/or sepsis in the region of the proposed injection and/or in the presence of septicaemia.

General contra-indication related to epidural anaesthesia, regardless of the local anaesthetic used should be taken into account.

WARNINGS: Safety in pregnancy and lactation other than in labour has not been established. In performing NAROPIN blocks, unintended IV injection is possible and may result in cardiac arrest. The potential for successful resuscitation has not been studied. NAROPIN should not be injected rapidly in large doses but rather in incremental doses. It is not recommended for emergency situations where a fast onset of anaesthesia is necessary. Local anaesthetics should only be employed by clinicians who are well versed in the diagnosis and management of dose related toxicity and other acute emergencies which might arise from the block to be employed, then only after insuring the immediate (without delay) availability of oxygen, other resuscitative drugs, cardiopulmonary resuscitative equipment, and the personnel resources needed for proper management of toxic reactions and related emergencies. Delay in proper management of dose related toxicity, under ventilation from any cause and/or altered sensitivity may lead to the development of acidosis, cardiac arrest and possibly, death. Solutions of NAROPIN should not be used for the production of obstetrical paracervical block anaesthesia, retrobulbar block, or spinal anaesthesia (subarachnoid block) due to insufficient data to support such use. Intravenous regional anaesthesia (Bier block) should not be performed due to a lack of clinical experience and a risk of attaining toxic blood levels of NAROPIN. Aspiration for blood, or cerebrospinal fluid (where applicable), must be done prior to injecting the original and all subsequent doses of any local anaesthetics to avoid intravascular or subarachnoid injection.

However a negative aspiration does not ensure against an intravascular or subarachnoid injection. A well known risk of epidural anaesthesia may be unintentional subarachnoid injection of local anaesthetic. NAROPIN should be used with caution in patients receiving local anaesthetics and agents structurally related to amide-type local anaesthetics, since the toxic effects of these drugs are additive.

DOSEAGE AND DIRECTIONS FOR USE: For dosage and directions for use see package insert.

SIDE EFFECTS AND SPECIAL PRECAUTIONS: Side-effects: Adverse event profile is similar to other long acting local anaesthetics of the amide type. Adults: most frequently reported of clinical importance regardless of casual relationship: Hypotension, nausea, bradycardia, vomiting, paraesthesia, back pain, temperature elevation, headache, urinary retention, dizziness, hypotension, rigors (chills), tachycardia, anxiety and hypoaesthesia. Hypotension and nausea are the most frequent side-effects. In children the most commonly reported adverse events (>1%) are vomiting, nausea and pruritus. Allergic reactions (in most severe instances anaphylactic shock) to local anaesthetics of the amide type are rare. Neuropathy and spinal dysfunction have been associated with regional anaesthesia, regardless of the type of local anaesthetic used. NAROPIN may cause acute toxic effects after high doses or if very rapidly rising blood levels occur due to accidental intravascular injection or overdose.

Special precautions: WHEN ANY LOCAL ANAESTHETIC AGENT IS USED, RESUSCITATIVE EQUIPMENT AND DRUGS, INCLUDING OXYGEN, SHOULD BE IMMEDIATELY AVAILABLE IN ORDER TO MANAGE POSSIBLE ADVERSE REACTIONS INVOLVING THE CARDIOVASCULAR, RESPIRATORY OR CENTRAL NERVOUS SYSTEMS. BECAUSE OF THE POSSIBILITY OF HYPOTENSION AND BRADYCARDIA FOLLOWING MAJOR BLOCKS, AN IV CANNULA SHOULD BE INSERTED BEFORE THE LOCAL ANAESTHETIC IS INJECTED.

INJECTION SHOULD ALWAYS BE MADE SLOWLY WITH FREQUENT ASPIRATIONS TO AVOID INADVERTENT INTRAVASCULAR INJECTION, WHICH CAN PRODUCE TOXIC EFFECTS.

When neuraxial anaesthesia is employed patients who are to be anticoagulated using low molecular weight heparin and heparinoids are at risk of developing an epidural or spinal haematoma, which can result in long-term or permanent paralysis. Safety and efficacy depends on proper dosage, correct technique and adequate precautions. Lowest dosage that results in efficacious anaesthesia should be used. Elderly, young and debilitated patients, including those with partial or complete heart conduction block, advanced liver disease or severe renal dysfunction should be given reduced doses commensurate with their age and physical condition. Children between 1-12 should be given doses commensurate with their weight and clinical status. NAROPIN is not recommended in children under the age of one year. No dose modification is necessary in patients with impaired renal function when used for single dose of short-term treatment. Acidosis and reduced plasma protein concentration may increase the risk of systemic toxicity. Possibility of hypotension and bradycardia following epidural blockade should be anticipated and precautions taken. Partial or complete heart block. Certain local anaesthetic procedures such as injection in the head and neck region, including retrobulbar, dental and stellate ganglion block may be associated with a higher frequency of serious adverse reactions regardless of the local anaesthetic used. Ropivacaine should be used with caution in patients with known drug sensitivities. Careful and constant monitoring of cardiovascular and respiratory vital signs and the patient's state of consciousness should be accomplished after each local anaesthetic injection. It should be kept in mind that at such times restlessness, anxiety, tinnitus, dizziness, blurred vision, tremors, depression or drowsiness may be early warning signs of CNS toxicity. Local anaesthetics should be given with great caution (if at all) to patients with pre-existing abnormal neurological pathology, e.g. myasthenia gravis. Use with extreme caution in epidural, caudal and spinal anaesthesia when there are serious diseases of the CNS or of the spinal cord, e.g. meningitis, spinal fluid block, cranial or spinal haemorrhage, tumours, poliomyelitis, syphilis, tuberculosis or metastatic lesions of the spinal cord. Due to NAROPIN being metabolised in the liver it should be used with caution in patients with severe liver disease and repeated doses may need to be reduced due to delayed elimination. The risk should also be considered in patients suffering from malnutrition or patients with hypovolaemia.

Effects on ability to drive and use machines: Dose-dependant - may have an effect on mental function and co-ordination even in the absence of overt central nervous system toxicity and may temporarily impair locomotion and alertness.
 Pregnancy and lactation: (See Contra-Indications)
INTERACTIONS: Should be used with caution in patients receiving other local anaesthetic or agents structurally related to amide-type local anaesthetics, since the toxic effects are additive. There is a potential risk for metabolic interaction when ropivacaine is used in combination with CYP1A inhibitors, e.g. verapamil and fluvoxamine, which may result in increased plasma levels of ropivacaine.

REGISTRATION NUMBERS:

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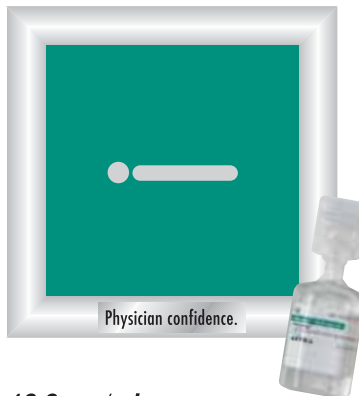
DETAILS OF THE REGISTERED LICENCE HOLDER: AstraZeneca Pharmaceuticals (Pty) Limited
 5 Leeuwkop Road, Sunninghill, 2157, Private Bag X30, Sunninghill, 2157 Reg. No. 1992/005854/07
 (011) 797 6000

Ref: PI (28/11/2002)

For full details relating to any information mentioned above please refer to the package insert of NAROPIN.

NAROPIN Range
 Indication: Surgical anaesthesia, acute pain management, acute pain management in paed.
 Date compiled: 16/02/2004

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