

Regional anesthesia in total cystectomy - our experience

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the amplitude for optimal viewing on the monitor, and without a graphic representation it cannot reliably define the onset of an epidural blockade.

CONCLUSION

The expected vasodilatation in the lower extremities is a very important factor in biomechanics of bone healing. Normal compensatory vasoconstriction in the upper extremities shows apparent changes in both skin temperature and amplitude of the pulse oximeter waveform. This difference in local perfusion may make the foot a preferable site for reliable pulse oximeter measurement during lumbar epidural anesthesia.

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REGIONAL ANESTHESIA IN TOTAL CYSTECTOMY – OUR EXPERIENCE

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INTRODUCTION

Regional anesthesia in total cystectomy as one of the methods. The aim of this study is to estimate whether this method increases bleeding during radical urinary bladder cystectomy.

METHODS

We have presented our experience with 27 patients during a period of two years. An epidural catheter was applied to 9 patients (group 2) through a needle of 18 G, at the level of L₂/L₃ using the method of a "hanging drop". We have chosen the area of the spine in order to diminish the risk of instability of hemodynamics, caused by a higher level block (Th 5). At the end of the catheter a bacterial filter is placed to prevent possible complications (infections).

RESULTS

All the patients who had total cystectomy were about 65.5 years of age, body weight 70 kg, ASA II/III. An average duration of the operation was 345 minutes and the mean intraoperative CVP was 8 to 9 cm H₂O. Blood consumption was the same in both groups (mean 2.5 units) as well as the value of the pre- and postoperative hemogram. According to Student's t test the group with a continuous epidural anesthesia had a statistically significant difference of intraoperative systemic pressure fall in relation to the control group. Analgesic and anesthetic consumption in the control group¹ was considerably greater. Peristalsis appears approximately the third day after operation in both groups.

CONCLUSION

Total cystectomy is an extensive operative intervention, and epidural anesthesia does not provoke massive bleeding, although the sympathetic blockage is present and the blood vessels of the lower part of the body are dilated, and their basin increased. The fall of blood pressure is not so important as to prevent the application of this method. Postoperative analgesia was shown to be sufficient in doses of 20 mg 0.5% Bupivacain twice daily.

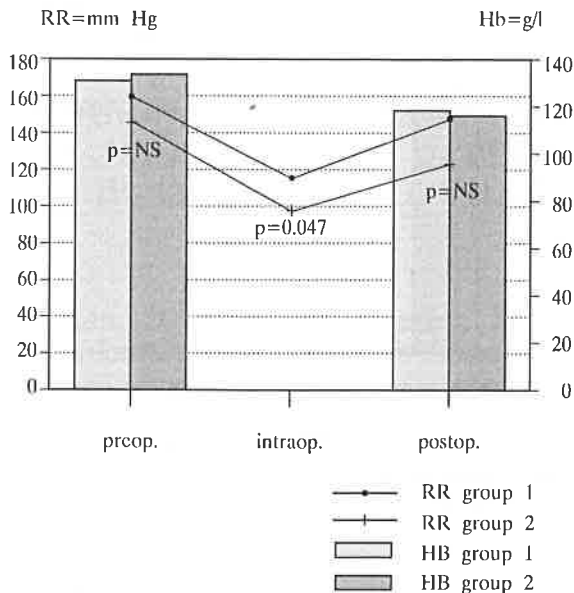


Figure 1. Correlation between blood pressure and Hb Non-epidural (gr. 1) vs epidural (gr. 2)

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OUR EXPERIENCE USING EPIDURAL ANALGESIA WITH PARTURIENTS

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INTRODUCTION

At the Clinic for Gynecology and Obstetrics we introduced in 1990 the continuous epidural analgesia (KEA) for painless parturition. Till now 586 parturitions were carried out with KEA.

The epidural analgesia belongs to an extremely luxurious form of obstetric analgesia, and has particular obstetric indications: EPH gestoses, hypotensive conditions, autonomous hyporeflexia, distocia (uncoordinated activity) of uterus, diabetes mellitus of the mother, intrauterus abnormality and death of the fetus, epilepsy as well as non-cooperative parturient.

This method has, if correctly executed, great advantage over the system analgesia of the mother, positive effects on biochemical stress markers (11-OH - corticosteroids, insulin, glucose, free fatty acids, prolactin), and provides a pain relief during the whole parturition, evaluated in degrees of pain.

The benefits of KEA are:

1. For the mother: excellent pain reduction; decrease of metabolic disturbance and dehydration; the mother is relaxed, cooperative and physiologically in order.
2. For the newborn: improves circulation in placenta caused by good hydration, vasodilatation and obligatory lateral position.

The purpose of this study was to establish any unpleasantness for the newborn baby or the mother trained or assisted with application of KEA.

The difference between proportions was tested for all parturitions completed by operation or vacuum-extraction (VE) or cesarean section (CS) in groups of 100 painless parturitions with the KEA method.

In evaluating the vitality of the baby at delivery, we used the Apgar score in the first and fifth minute in both groups of tested patients.

METHOD

After a regular obstetric examination, with a cervix opening by 3-4 cm, an intravenous line was established and 500-1000 ml of crystalloid solution was applied. The placing of the epidural catheter was performed with the patient in the lateral position. The puncture was made in the midline at the levels L₃-L₄ or L₄-L₅, 18 G by