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ESRA MEETING ANNUAL UPDATE

1 day, 1 programme, 3 cities

ROMA, 13 APRILE 2024

Responsabili scientifici:

Mario Bosco

Fabio Costa

Fabrizio Fattorini





POLICLINICO UNIVERSITARIO CAMPUS BIO-MEDICO DI ROMA

**Scuola di Anestesia, Rianimazione, Terapia Intensiva e del Dolore
Direttore: Prof. Felice Eugenio Agrò**

Dichiaro di non avere conflitti di interessi.



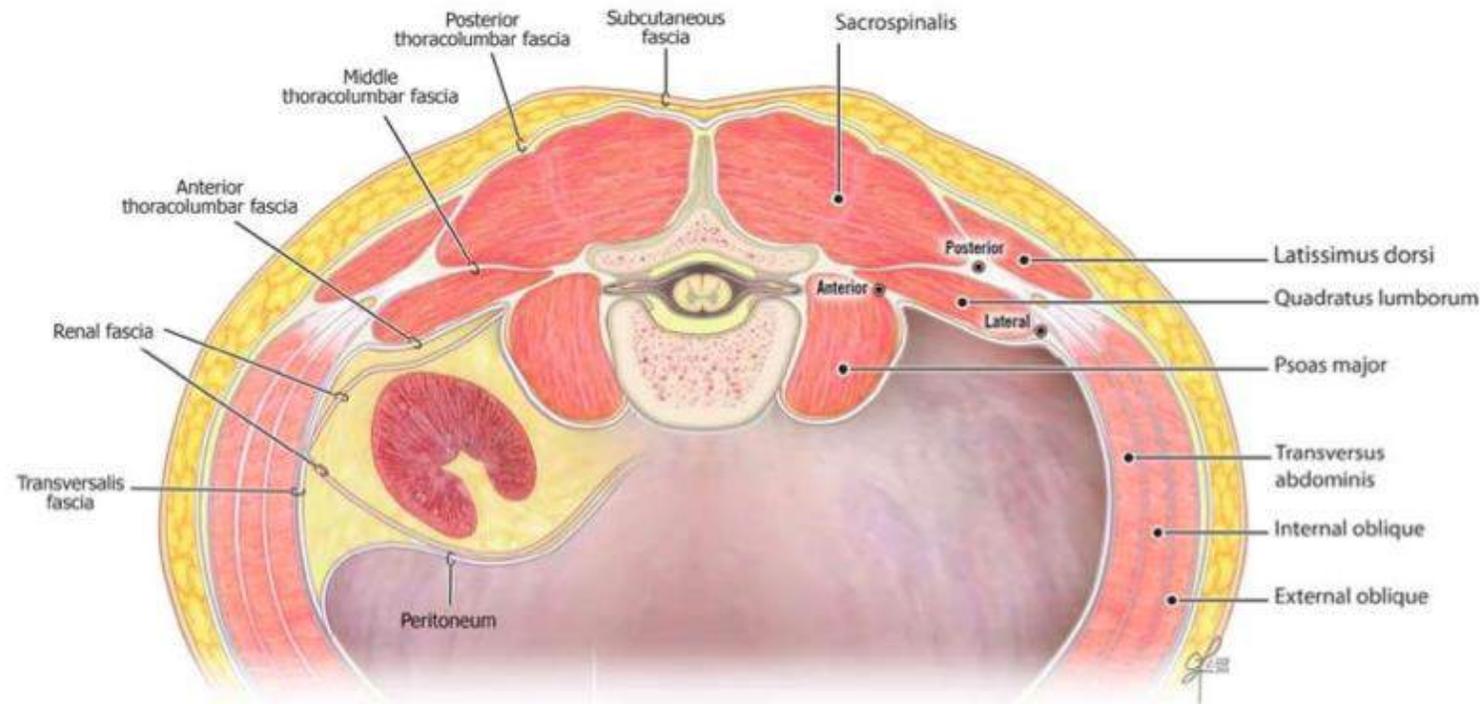
Comment > Reg Anesth Pain Med. 2016 Jul-Aug;41(4):548-9.

doi: 10.1097/AAP.0000000000000411.

Quadratus Lumborum Block Nomenclature and Anatomical Considerations

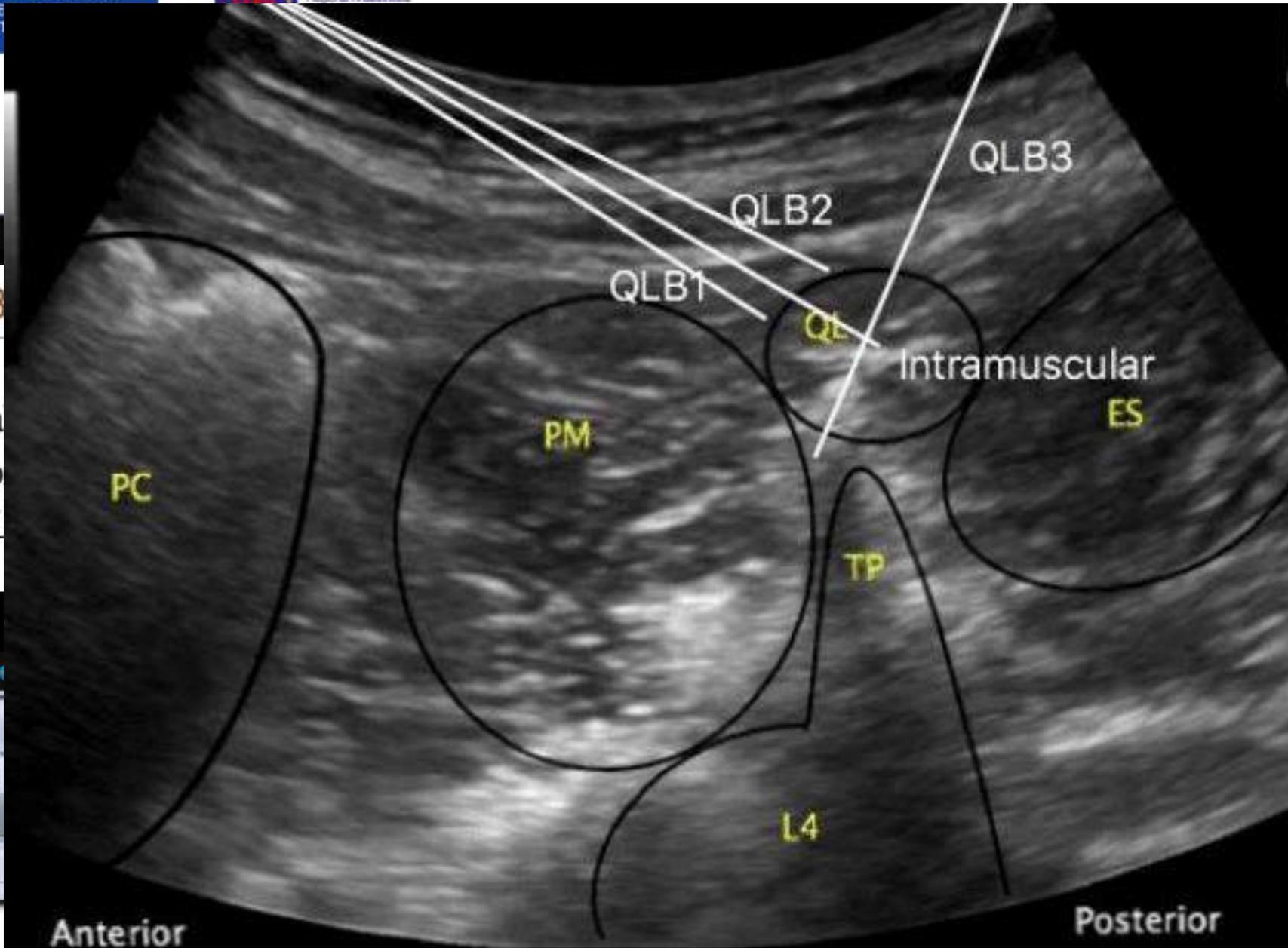
Kariem El-Boghdadly¹, Hesham Elsharkawy, Anthony Short, Ki Jinn Chin

scription supplied in the methodology. We consider it important to establish a nomenclature that will adequately distinguish between the different approaches to the QL block, thereby allowing clearer interpretation of the literature should differences in clinical efficacy begin to emerge in future studies, as they did for the TAP block.



Types of QLB

Since the initial
block are performed
or posterior QL



[van Veličković³](#)

Types of the
QLB, QLB 2



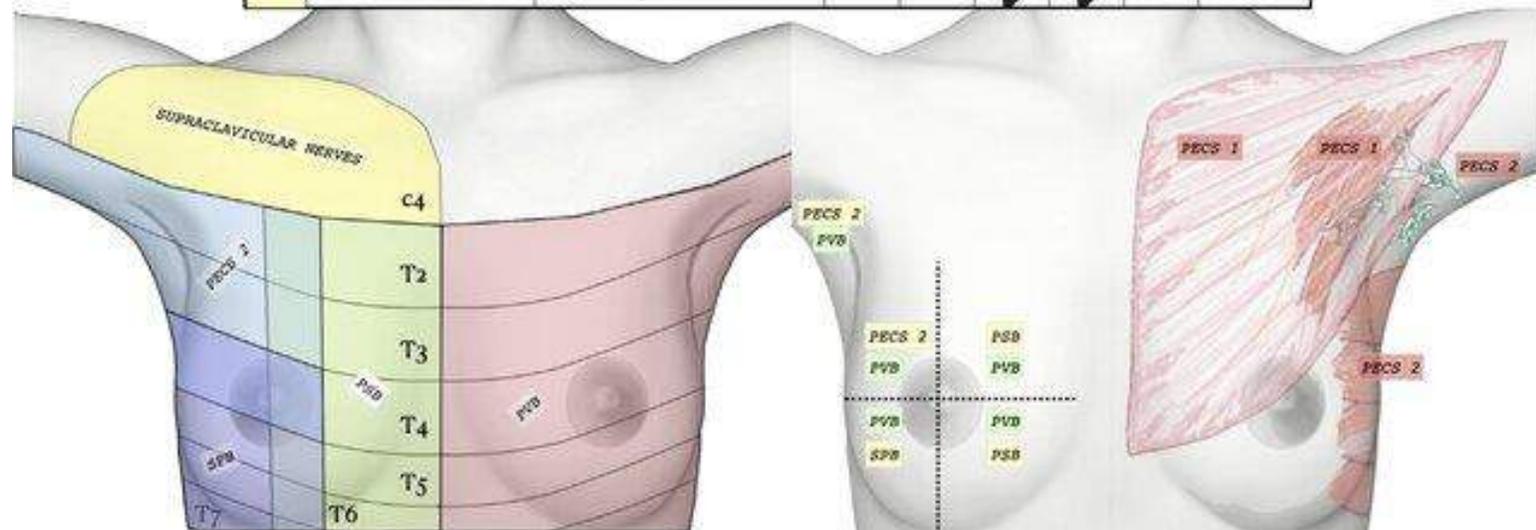
Breast surgery analgesia: another perspective for PROSPECT guidelines

F. Cosca, A. Strumia, L. M. Remore, G. Pascarella, R. Del Buono, M. Tedesco, G. Sepolere, P. Scimia, P. Fusco

2020

Che blocco gli faccio in senologia?

	Anatomical involvement	Innervation	PVB	PECS 1	PECS 2	SPB	PSB	Local infiltration
	Lumpectomy							✓
	Axillary skin	Intercostobrachial nerve (T1-T2)	✓		✓			✓
	Deep axillary structures				✓			
Skin and gland								
	Infraclavicular region	Supraclavicular nerves (C3-C4)						✓
Mastectomy	Upper outer quadrant	Lateral cutaneous branches T2-T4	✓		✓			✓
	Lower outer quadrant	Lateral cutaneous branches T4-T6	✓			✓		✓
	Upper inner quadrant	Anterior cutaneous branches T2-T4	✓				✓	✓
	Lower inner quadrant	Anterior cutaneous branches T4-T6	✓				✓	✓
Muscles								
Implants	Pectoralis major muscle	Lateral and medial pectoral nerves		✓	✓			
	Pectoralis minor muscle	Medial pectoral nerves		✓	✓			
	Serratus anterior	Long thoracic nerves			✓	✓		



2021

Standardizing nomenclature in regional anesthesia: an ASRA-ESRA Delphi consensus study of abdominal wall, paraspinal, and chest wall blocks

Kariem El-Boghdady^{1,2}, Morné Wolmarans³, Angela D Stengel⁴, Eric Albrecht⁵,
 KI Jinn Chin⁶, Hesham Elsharkawy^{7,8}, Sandra Kopp⁹,
 Edward R Mariano^{10,11}, Jeff L Xu^{12,13}, Sanjib Adhikary¹⁴, Başak Altıparmak¹⁵,
 Michael J Barrington¹⁶, Sébastien Bloc^{17,18}, Rafael Blanco¹⁹, Karen Boretsky²⁰,
 Jens Børglum²¹, Margaretha Breebaart²², David Burckett-St Laurent²³,
 Xavier Capdevila²⁴, Brendan Carvalho²⁵, Alwin Chuan²⁶, Steve Coppens²⁷,
 Ioana Costache²⁸, Mette Dam²⁹, Christian Egeler³⁰, Mario Fajardo³¹,
 Jeff Gadsden³², Philippe Emmanuel Gautier³³, Stuart Alan Grant³⁴, Admir Hadzic^{35,36},
 Peter Hebbard³⁷, Nadia Hernandez³⁸, Rosemary Hogg³⁹, Margaret Holtz⁴⁰,
 Rebecca L Johnson⁴¹, Manoj Kumar Karmakar⁴², Paul Kessler⁴³,
 Kwesi Kwofie⁴⁴, Clara Lobo⁴⁵, Danielle Ludwin⁴⁶, Alan MacFarlane⁴⁷,
 John McDonnell⁴⁸, Graeme McLeod^{49,50}, Peter Merjavy⁵¹, EML Moran⁵²,
 Brian D O'Donnell⁵³, Teresa Parras⁵⁴, Amit Pawa^{55,56}, Anahi Perlas⁵⁷,
 Maria Fernanda Rojas Gomez⁵⁸, Xavier Sala-Blanch^{59,60}, Andrea Saporito⁶¹,
 Sanjay Kumar Sinha⁶², Ellen M Soffin⁶³, Athmaja Thottungal⁶⁴, Ban C H Tsui⁶⁵,
 Serkan Tulgar⁶⁶, Lloyd Turbitt⁶⁷, Vishal Uppal⁶⁸, Geert J van Geffen⁶⁹,
 Thomas Volk^{70,71}, Nabil M Elkassabary^{72,73}

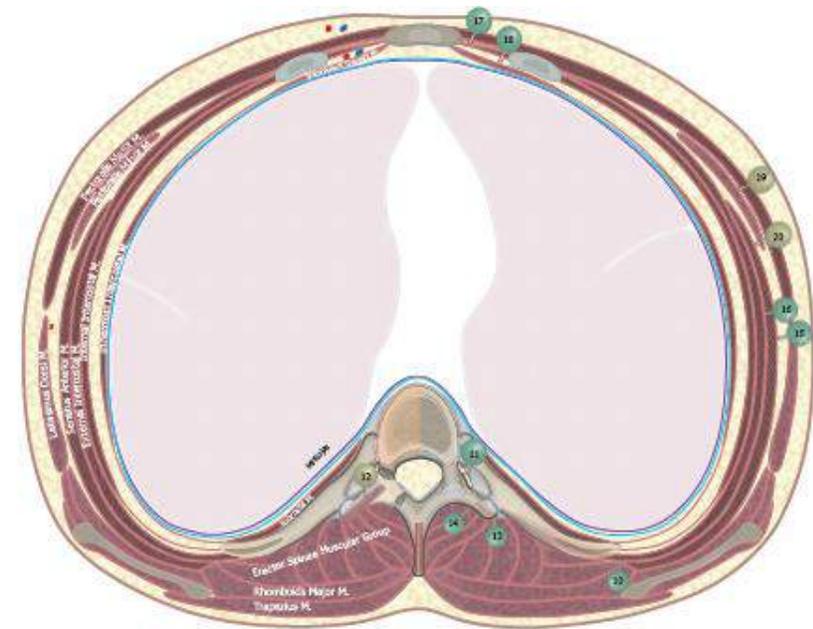


Figure 4 Illustrations of recommended names and anatomical locations of injection for paraspinal and chest wall. Green circles represent strong consensus, yellow circles represent weak consensus. (10) Rhomboid intercostal plane block; (11) paravertebral block; (12) intertransverse process block; (13) erector spinae plane block; (14) retrolaminar block; (15) superficial serratus anterior plane (SAP) block; (16) deep SAP block; (17) superficial parasternal intercostal plane (PIP) block; (18) deep PIP block; (19) interpectoral plane block; (20) pectoroserratus plane block.

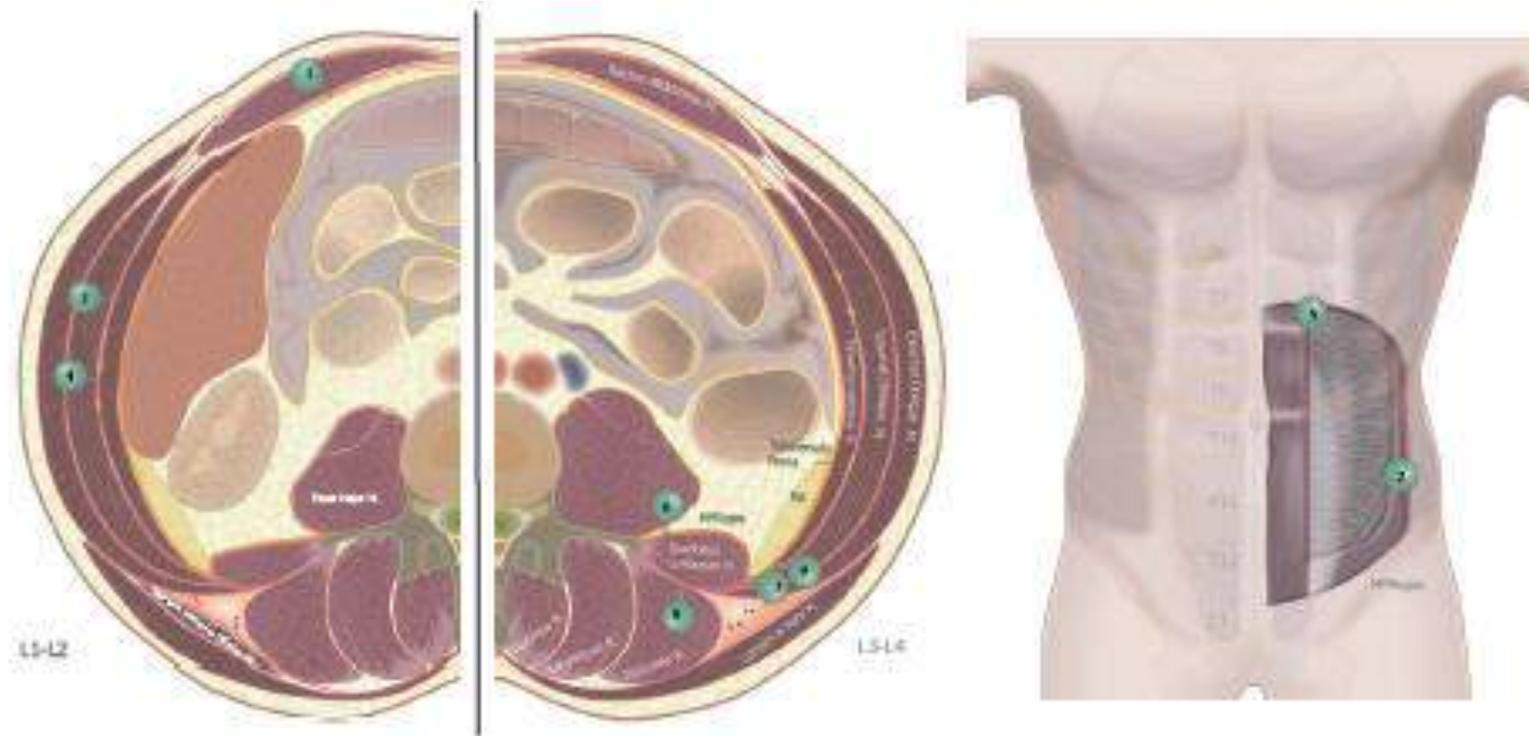
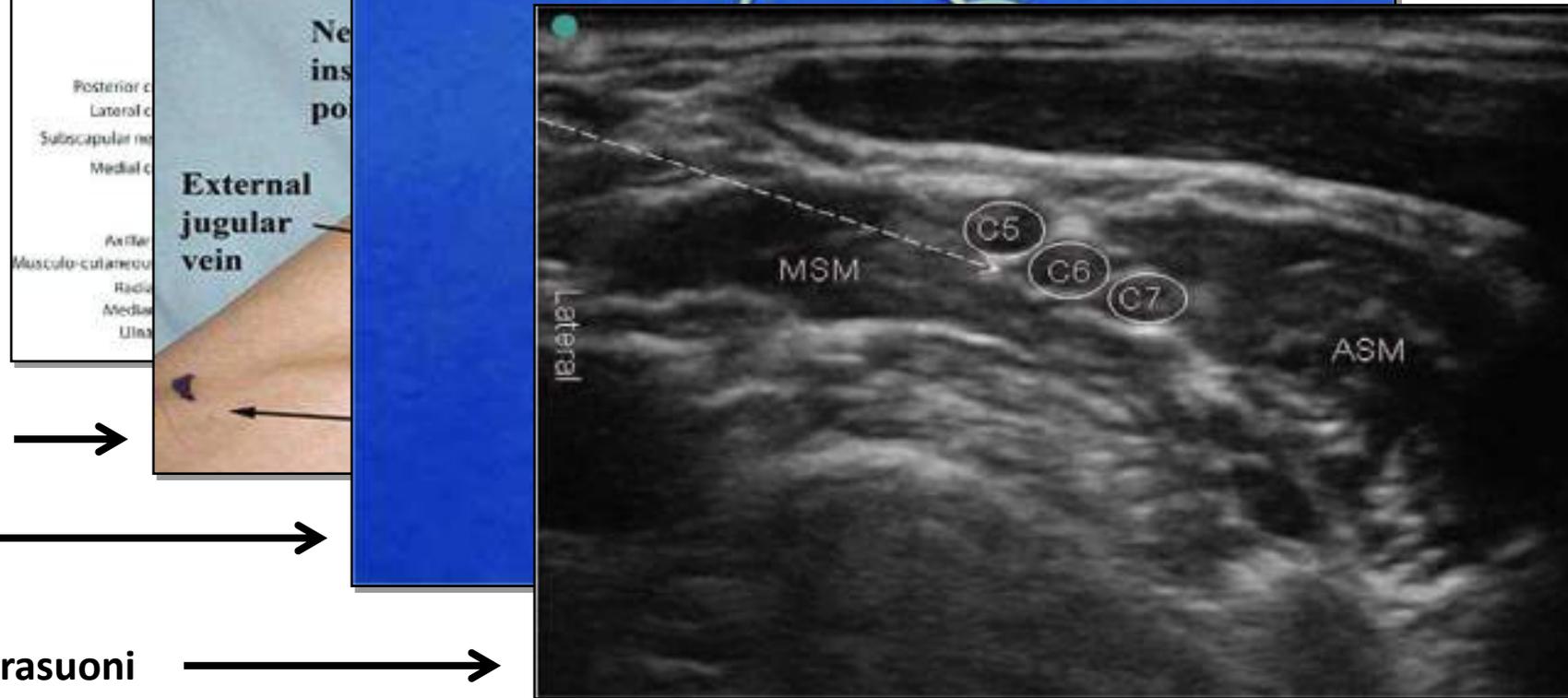


Figure 3 Illustrations of recommended names and anatomical locations of injection for abdominal wall. (1) Rectus sheath block; (2) ilioinguinal iliohypogastric nerves block; (3) transverse abdominis plane (TAP); (4) midaxillary TAP block; (5) subcostal TAP block; (6) anterior quadratus lumborum block (QLB); (7) lateral QLB; (8) posterior QLB; (9) transversalis fascia plane block.

Course of the brachial plexus

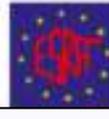
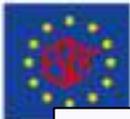


Anatomia →

Punti di repere cute →

ENS →

Ultrasuoni →



Techniques

☰ Filter

Category

- Ankle block
- Cutaneous blocks of the lower extremity
- Fascia Iliaca Block
- Femoral nerve block
- Lumbar plexus block
- Obturator nerve block
- Popliteal sciatic nerve block
- Saphenous nerve block
- Sciatic nerve block
- Lower Extremity Blocks

Techniques

☰ Filter

Category

- Axillary brachial plexus block
- Blocks at the elbow
- Cutaneous blocks of the upper extremity
- Infraclavicular brachial plexus block
- Interscalene brachial plexus block
- Supraclavicular brachial plexus block
- Wrist block
- Upper extremity blocks

2023

Sta
an
lov

regional anesthesia:
study of upper and



Kariem El-Boghdadly¹ Eric Albrecht^{2,3} Mo
Edward R Mariano^{4,5,6} Sandra Kopp⁷ Anah
Jeff Gadsden,⁸ Serkan Tulgar⁹ Sanjib Adhikary
Anne M R Agur,¹² Başak Altıparmak¹³ Michael
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Ioana Costache³⁰ Mette Dam³¹ Matthias
Christian Egeler,³⁴ Hesham Elsharkawy³⁵ Thor
Ben Fox,³⁷ Carlo D Franco³⁸ Philippe Emmanuel
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Brian M Ilfeld^{49,50} Vivian H Y Ip⁵¹ Rebecca
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vin,⁶⁰ Alan James Robert Macfarlane^{61,62}
McCartney,⁶⁴ John McDonnell,⁶⁵
vros G Memtsoudis⁶⁸ Peter Merjavy,⁶⁹
n Nader⁷¹ Joseph M Neal⁷²
ne Njathi-Ori,⁵² Brian D O'Donnell,⁷⁴ Matt Oldman,⁷⁵
a Parras,⁷⁷ Amit Pawa^{78,79} Philip Peng⁸⁰
ulos,⁵² Xavier Sala-Blanch^{82,83} Andrea Saporito,⁸⁴
venk⁸⁶ Maria Paz Sebastian⁸⁷
Navdeep Sand,⁸⁹ Sanjay Kumar Sinha,⁸⁹ Ellen M Soffin⁹⁰ James Stimpson,⁹¹
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Vermeulen⁹⁷ Kamen Vlassakov⁹⁸ Thomas Volk,⁹⁹
assabany¹⁰²



used to provide anesthesia and analgesia for a range of surgical procedures. The advent of ultrasound-guidance with improved sonoanatomical understanding has enabled clinicians and researchers to refine regional anesthetic approaches and develop novel ones. While this has likely led to improvements in patient care, the natural tendency to apply a different label to each new variation, to distinguish it from previous iterations, has led to an unwieldy expansion of the nomenclature in regional anesthesia techniques. This contributes to inconsistent communication in clinical and academic settings, which not only undermines teaching and training in regional anesthesia and related disciplines, but may also hamper interpretation and synthesis of clinical research. As a consequence, this may have implications for safe adoption of these techniques and patient access to regional anesthesia.¹



METHODS

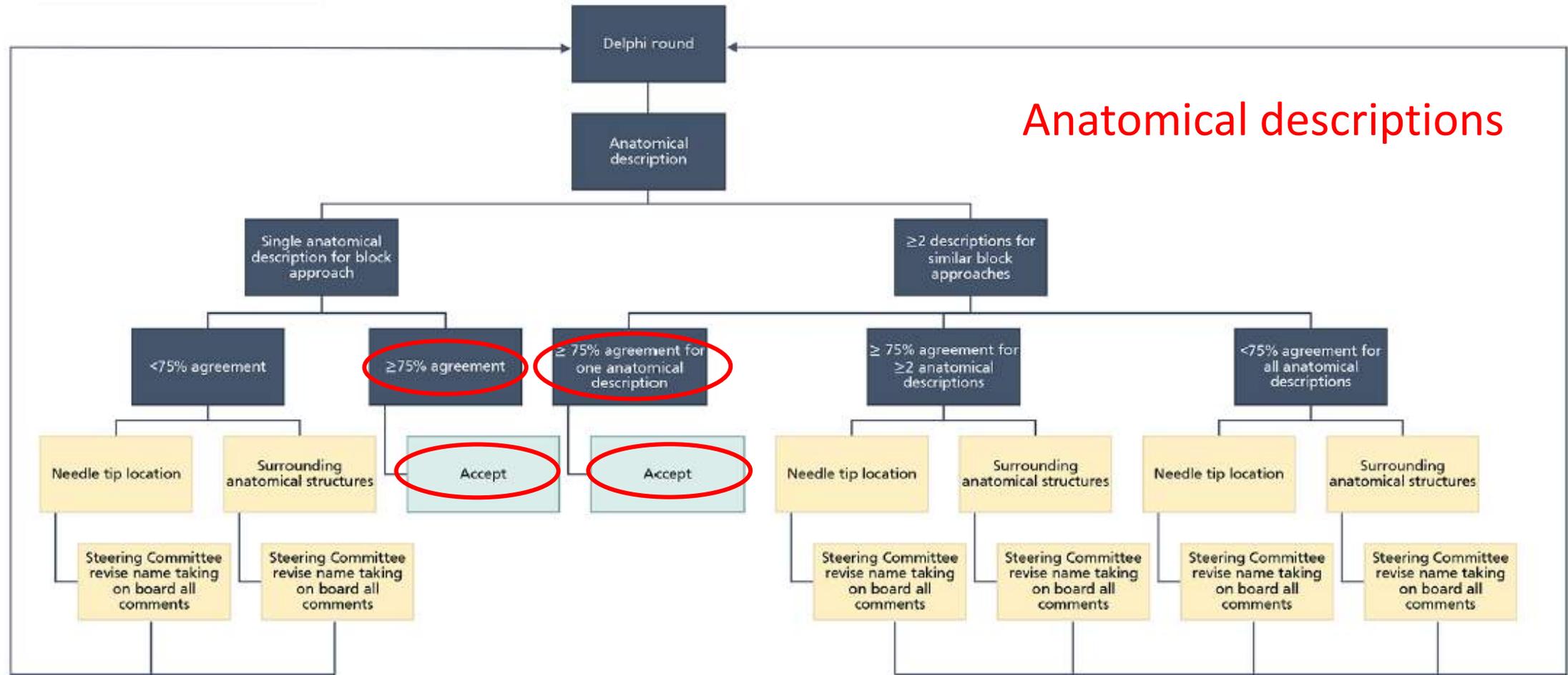
Six representatives from the American Society of Regional Anesthesia and Pain Medicine and European Society of Regional

Scope

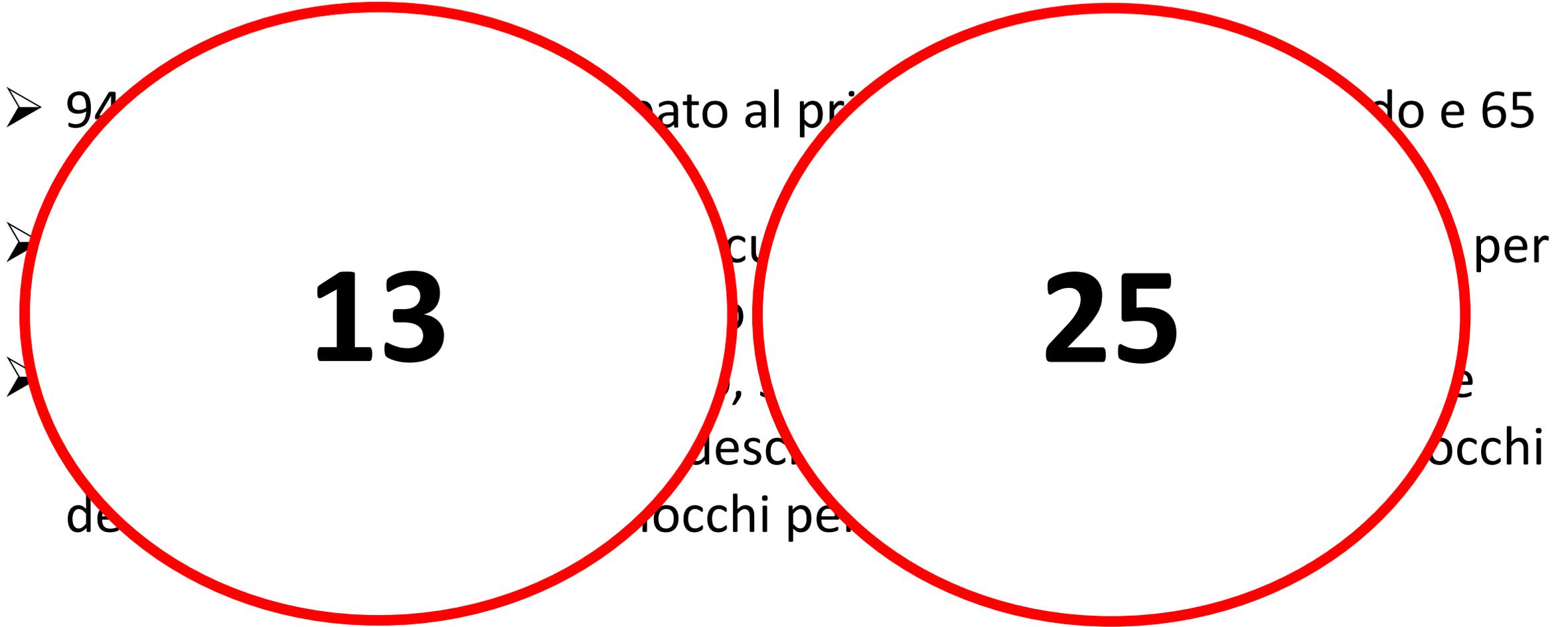
We aimed to achieve consensus on two characteristics of common upper and lower limb peripheral nerve blocks: names by which they are referred to, and anatomical descriptions for the position of the needle-tip during injection for each of these regional anesthetic techniques. Names were defined as the word or set of words by which each technique is known, addressed, or referred to. Anatomical descriptions were defined by the anatomical loca-

supplemental appendix 1. In brief, a modified three-round Delphi approach was used, with two rounds of electronic questionnaires and a third round-table discussion round.

Anatomical descriptions



RESULTS



ARTO SUPERIORE

Table 1 Consensus achieved for upper limb block names and anatomical descriptions

Name (%)	Anatomical description (%)
1 Interscalene brachial plexus block (98)	Injection at the C5 and C6 nerve roots between anterior and middle scalene muscles (83)
2 Superior trunk block (92)	Injection at the superior trunk before the suprascapular nerve emerges (80)
3 Supraclavicular brachial plexus block (99)	Injection at the divisions of the brachial plexus immediately cephalad to the clavicle (78)
4 Infraclavicular brachial plexus block (82)	Injection at the cords of the brachial plexus (87)
5 Infraclavicular brachial plexus block (retroclavicular approach) (78)	Injection at the cords of the brachial plexus where the needle insertion is proximal to the clavicle (72)
6 Infraclavicular brachial plexus block (costoclavicular approach) (85)	Injection at the cords of the brachial plexus in the medial infraclavicular fossa at the first part of the axillary artery (90)
7 Infraclavicular brachial plexus block (coracoid approach) (85)	Injection at the cords of the brachial plexus in the lateral infraclavicular fossa at the second part of the axillary artery (82)
8 Axillary brachial plexus block (95)	Injection at the branches of the brachial plexus in the axillary region (66)
9 Suprascapular nerve block (anterior approach) (87)	Injection of the suprascapular nerve coming off superior trunk and traveling to posterior neck under the posterior belly of omohyoid muscle (84)
10 Suprascapular nerve block (posterior approach) (89)	Injection of the suprascapular nerve in the suprascapular notch or suprascapular fossa (84)
11 Deep cervical plexus block (95)	Injection at one of more of the nerve roots of C2, 3, and 4, deep to the prevertebral fascia (88)
12 Intermediate cervical plexus block (93)	Injection deep to the investing fascia and superficial to the prevertebral fascia at the midpoint of the posterior border of sternocleidomastoid muscle (93)
13 Superficial cervical plexus block (98)	Injection superficial to the investing fascia at the midpoint of the posterior border of sternocleidomastoid muscle (85)

Strong consensus ($\geq 75\%$ agreement) was achieved for all block names and anatomical descriptions except for descriptions for the infraclavicular brachial plexus block (retroclavicular approach) and axillary brachial plexus block, which had weak consensus (50%–74% agreement).

INFRACLAVICULAR BLOCK

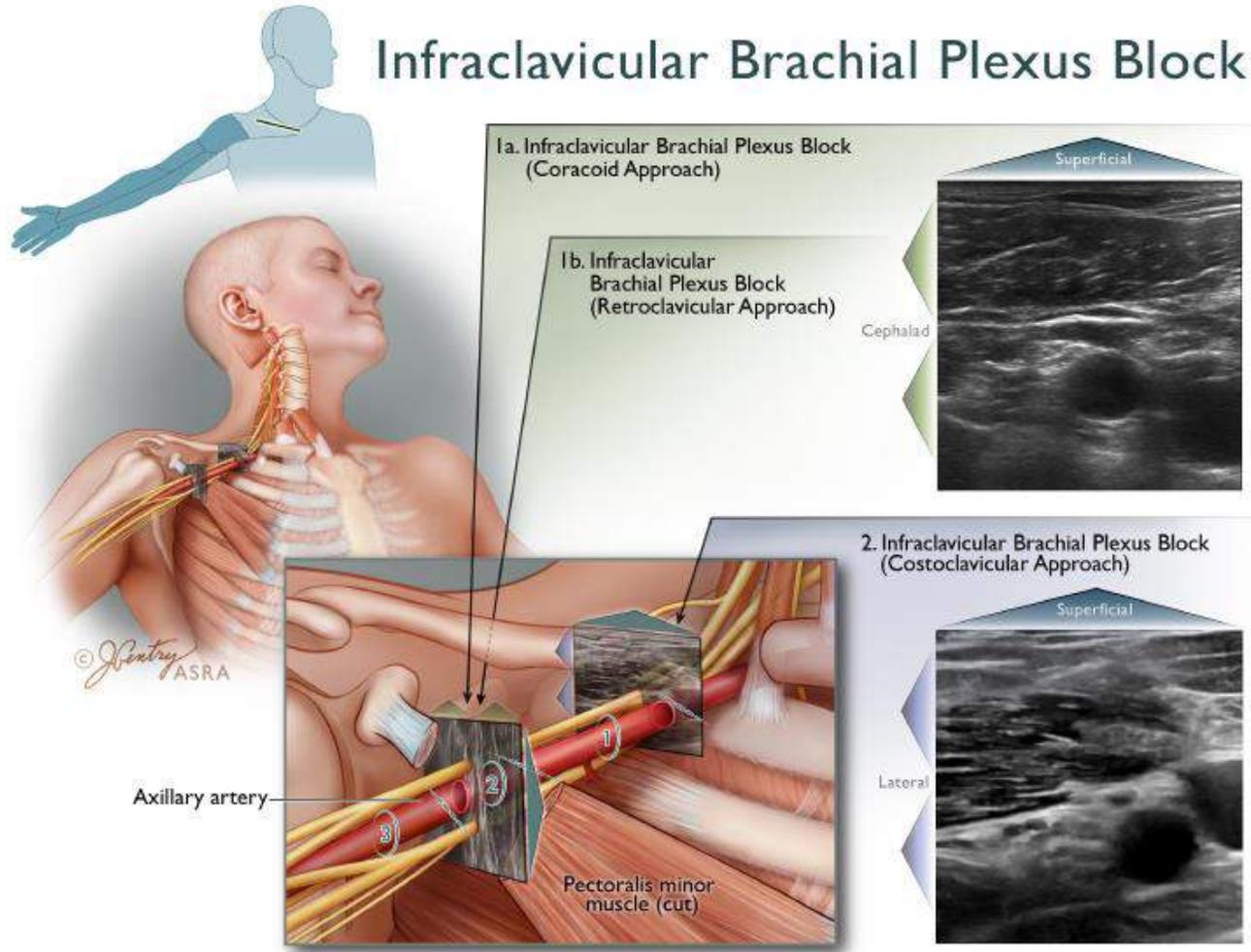
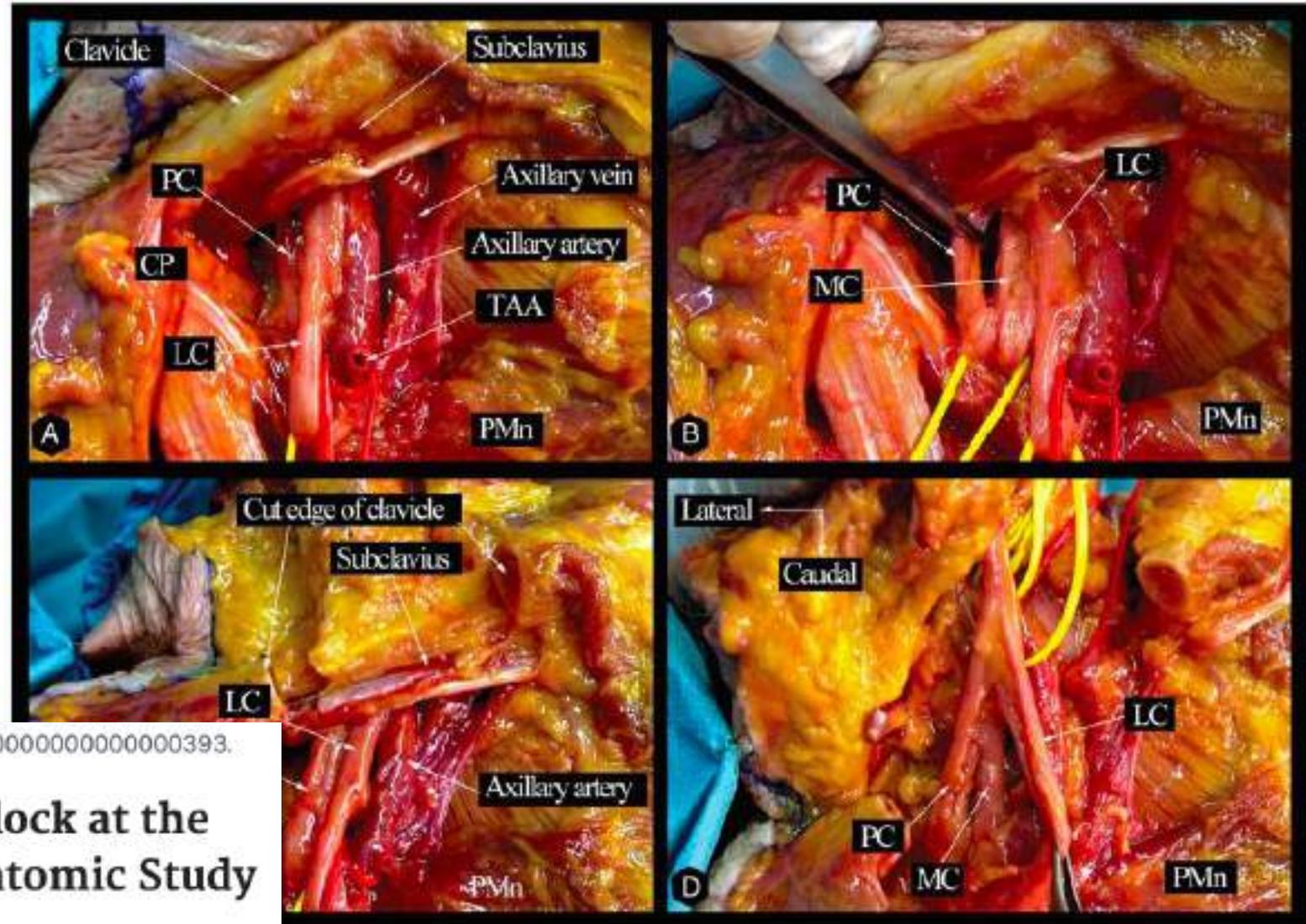


Figure 3 Three approaches to the infraclavicular brachial plexus block relative to the first, second and third parts (proximal, deep to, and distal to the pectoralis minor muscle, respectively) of the axillary artery. ASRA, American Society of Regional Anesthesia.

COSTOCLAVICULAR APPROACH

AA= axillary artery
 PMn = The pectoralis minor muscle
 CP= Coracoid process
 LC=lateral cord
 PC=posterior cord
 MC=medial cord
 TAA=thoracoacromial artery



> Reg Anesth Pain Med. 2016 May-Jun;41(3):387-91. doi: 10.1097/AAP.0000000000000393.

Anatomic Basis for Brachial Plexus Block at the Costoclavicular Space: A Cadaver Anatomic Study

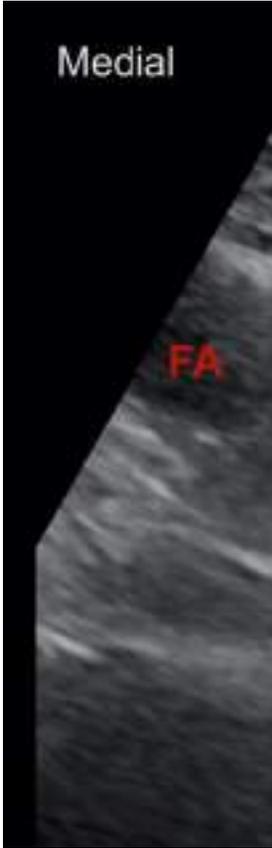
Xavier Sala-Blanch ¹, Miguel Angel Reina, Pawinee Pangthipampai, Manoj Kumar Karmakar

Table 2 Consensus achieved for lower limb block names and anatomical descriptions

Name (%)	Anatomical description (%)
1 Lumbar plexus block (97%)	Injection at the level of the lumbar roots (L2–4) coursing in the posterior third of the psoas muscle (95%)
2 Sacral plexus block (98%)	Injection at the sacral plexus just medial to the posterior border of the ischium. The plexus lies deep to the piriformis muscle lateral to the inferior gluteal vessels (79%)
3 Fascia iliaca block (suprainguinal approach) (99%)	Injection deep to the fascia iliaca over the surface of the iliacus muscle, and proximal to the inguinal ligament (78%)
4 Fascia iliaca block (infrainguinal approach) (98%)	Injection deep to the fascia iliaca, over the surface of the iliacus muscle, and lateral to the femoral nerve, distal to the inguinal ligament (85%)
5 Sciatic nerve block (transgluteal approach) (87%)	Injection at the sciatic nerve deep to the gluteus maximus muscle (96%)
6 Sciatic nerve block (infragluteal approach) (90%)	Injection at the sciatic nerve at the midthigh region distal to the inferior border of the gluteus maximus muscle (87%)
7 Sciatic nerve block (anterior approach) (86%)	Injection at the sciatic nerve between the adductor magnus anteriorly and gluteus maximus or biceps femoris muscles (93%)
8 Femoral nerve block (99%)	Injection at the femoral nerve cephalad to the bifurcation of the femoral artery, deep to the fascia iliaca (97%)
9 Pericapsular nerve group (PENG) block (77%)	Injection in the musculofascial plane between the psoas tendon anteriorly and the pubic ramus posteriorly (63%)
10 Pudendal nerve block (85%)	Injection at the pudendal nerve medial to the pudendal artery between the sacrospinous and sacrotuberous ligaments at the level of ischial spine (79%)
11 Femoral triangle block (76%)	Injection in the aponeurotic compartment containing the femoral vessels proximal to the apex of the femoral triangle. The apex of the femoral triangle is the point where the medial borders of the sartorius and adductor longus muscles cross (76%)
12 Adductor canal block (85%)	Injection in the aponeurotic compartment containing the femoral vessels distal to the apex of the femoral triangle and proximal to the adductor hiatus. The apex of the femoral triangle is the point where the medial borders of the sartorius and adductor longus muscles cross (80%)
13 Infiltration between the popliteal artery and capsule of the knee (86%)	Injection in the soft tissues between the popliteal artery and the posterior surface of the distal femur (92%)

PENG BLOCK

Pericapsular Nerve Group Block...

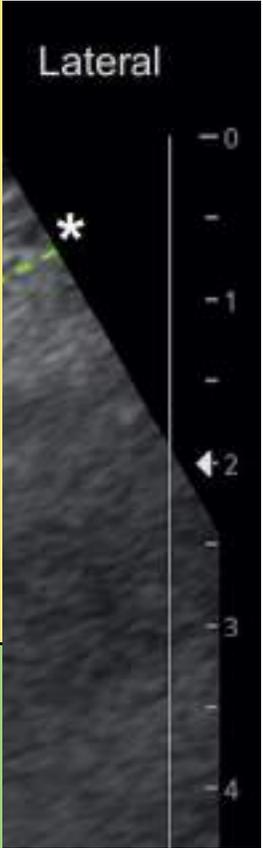


The ilio-pubic eminence (IPE), the iliopsoas muscle and tendon, the femoral artery, and pectineus muscle are imaged. Injection in the musculofascial plane between the psoas tendon anteriorly and the pubic ramus posteriorly.

Injection in the musculofascial plane between the psoas tendon anteriorly and the pubic ramus posteriorly.

31%

68%



ARTO INFERIORE

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13	Infiltration between the popliteal artery and capsule of the knee (86%)	Injection in the soft tissues between the popliteal artery and the posterior surface of the distal femur (92%)

FASCIA ILIACA

SUPRAINGUINAL



Injection deep to the fascia iliaca over the surface of the iliacus muscle, and proximal to the inguinal ligament.

INFRAINGUINAL



Injection deep to the fascia iliaca, over the surface of the iliacus muscle, and lateral to the femoral nerve, distal to the inguinal ligament

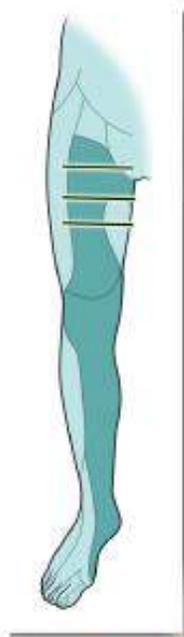
ARTO INFERIORE

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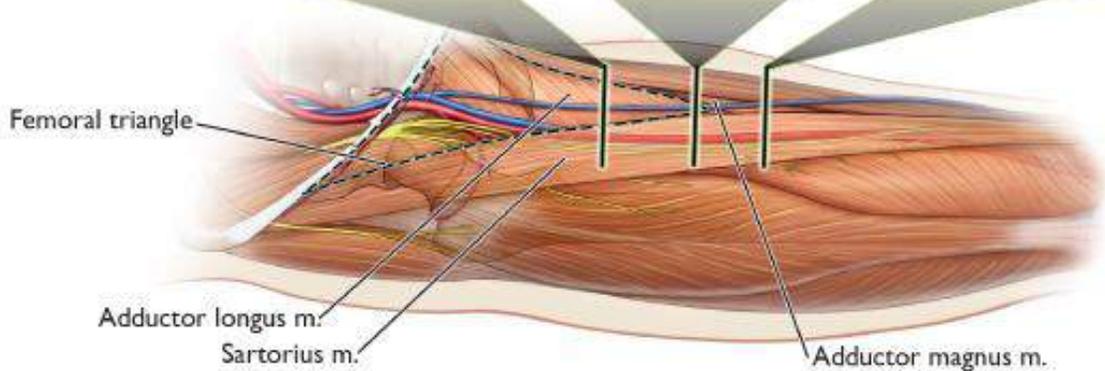
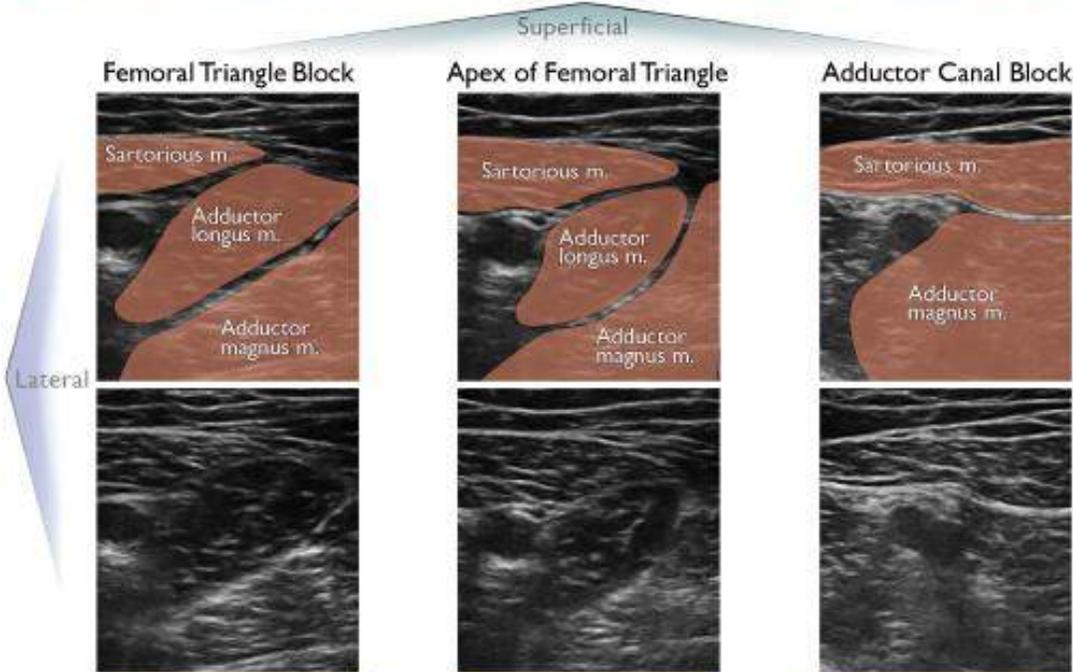
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CANALE DEGLI ADDUTTORI

Femoral Triangle Block and Adductor Canal Block



© Hentry ASRA



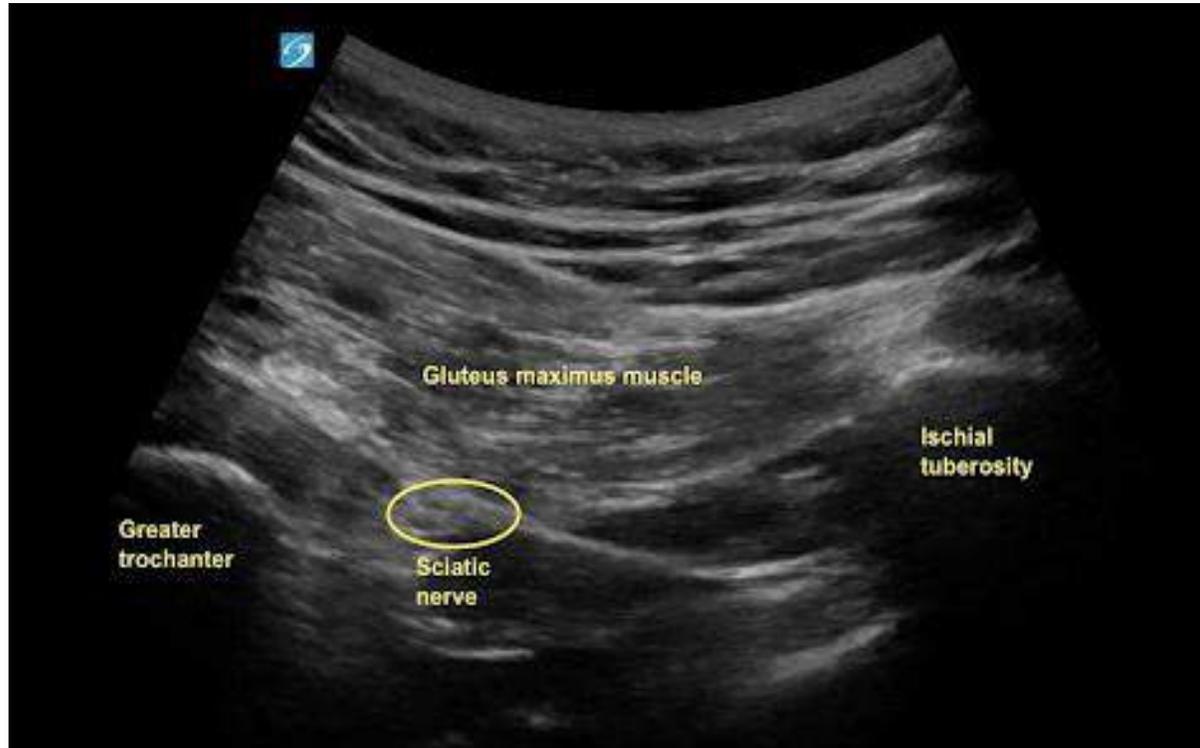
ARTO INFERIORE

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12	Adductor canal block (85%)	Injection in the aponeurotic compartment containing the femoral vessels distal to the apex of the femoral triangle and proximal to the adductor hiatus. The apex of the femoral triangle is the point where the medial borders of the sartorius and adductor longus muscles cross (80%)
13	Infiltration between the popliteal artery and capsule of the knee (86%)	Injection in the soft tissues between the popliteal artery and the posterior surface of the distal femur (92%)

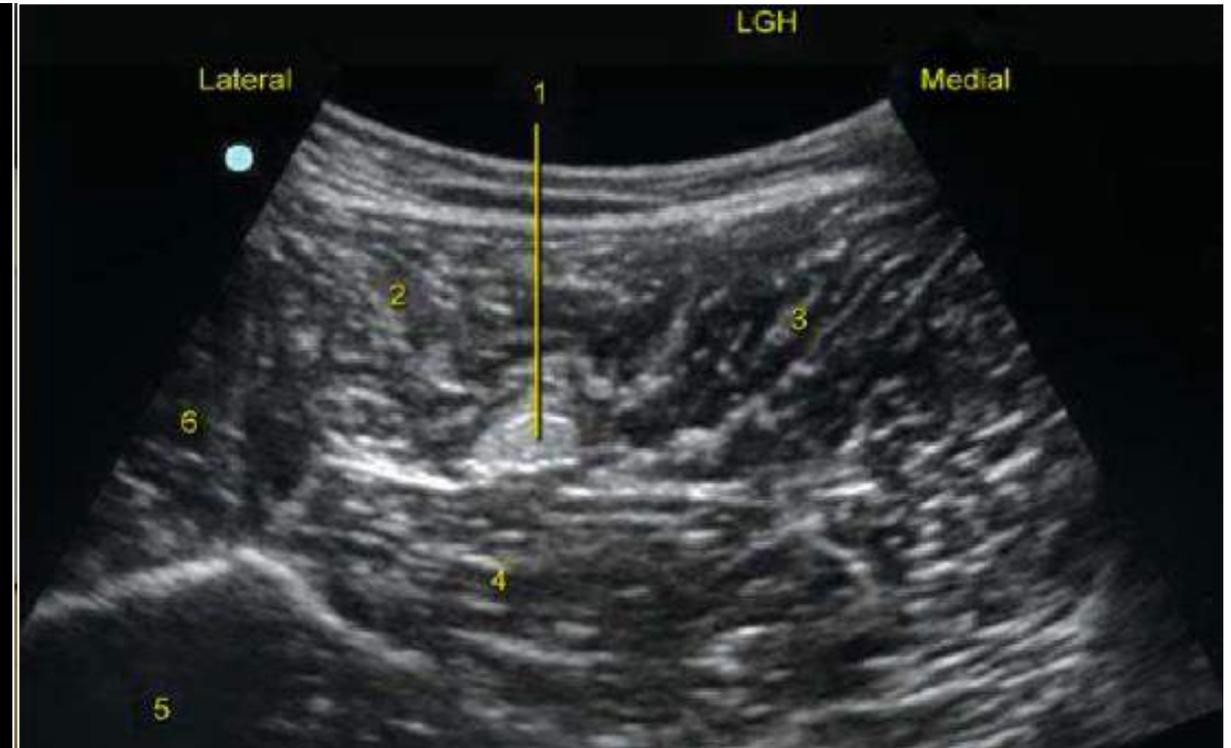
SCIATICO “ALTO”

TRANSGLUTEAL



Injection at the sciatic nerve deep to the gluteus maximus muscle.

INFRAGLUTEAL



Injection at the sciatic nerve at the midhigh region distal to the inferior border of the gluteus maximus muscle.

ARTO INFERIORE

14	Superior medial genicular nerves block (79%)	Injection at the superior medial genicular nerve next to the genicular artery on the medial side of the distal femur (75%)
15	Superior lateral genicular nerves block (80%)	Injection at the superior lateral genicular nerve next to the genicular artery on the lateral side of the distal femur (75%)
16	Inferior medial genicular nerves block (81%)	Injection at the inferior medial genicular nerve near the genicular artery at the junction of the medial condyle of the tibia and tibial shaft (67%)
17	Inferior lateral genicular nerves block (78%)	Injection at the inferior lateral genicular nerve near the genicular artery at the proximal fibula (69%)
18	Sciatic nerve block at the popliteal fossa (87%)	Injection at the sciatic nerve at or near the point of bifurcation in the popliteal fossa (91%)
19	Nerve to vastus medialis block (84%)	Injection at the nerve to vastus medialis where it is located deep to the sartorius and lateral to the saphenous nerve and femoral vessels in the femoral triangle (79%)
20	Common peroneal nerve block (90%)	Injection at the common peroneal nerve distal to sciatic nerve bifurcation (93%)
21	Ankle block (86%)	Injection at the five distal nerves that provide innervation of the foot at the level of the ankle: posterior tibial nerve, deep peroneal nerve, superficial peroneal nerve, saphenous and sural nerves (91%)
22	Deep peroneal nerve block (95%)	Injection at the deep peroneal nerve above the intermalleolar line, medial to the anterior tibial artery (84%)
23	Superficial peroneal nerve block (97%)	Injection at the superficial peroneal nerve superficially between the peroneus brevis and the extensor digitorum longus as a triangular hyperechoic shadow under the crural fascia. The extensor digitorum longus is anterior to the nerve, while the peroneus brevis is posterior to the nerve (88%)
24	Sural nerve block (92%)	Injection at the sural nerve above the lateral malleolus, anterior to the Achilles tendon and posterior to the peroneus brevis (90%)
25	Saphenous nerve block at the ankle (92%)	Injection at the saphenous nerve proximal to the medial malleolus, anterior to the great saphenous vein (94%)

Strong consensus ($\geq 75\%$ agreement) was achieved for all block names and anatomical descriptions except for descriptions for the PENG block, and inferior medial and lateral genicular nerve blocks, each of which had weak consensus (50%–74% agreement).

TAKE HOME MESSAGES

- La nomenclatura e l'anatomia per quanto talvolta possano apparire noiosi sono estremamente importanti, soprattutto in termini di didattica e ricerca scientifica.
- L'affinamento delle tecniche e delle conoscenze ci impone di essere rigorosi quando si parla di blocchi nervosi periferici, sia in termini di nomi che di visualizzazione sonoanatomica.

In the meantime...

