16-F, open-ended catheter, over the guide wire into the bladder and inflate the balloon. Remove the guide wire.

DISCUSSION

This technique is a useful tool for urologists and can be performed under local anaesthesia. It is particularly useful in the emergency setting and for high-risk patients who may not tolerate more definitive procedures.

Reference

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Intrapleural ropivacaine local anaesthetic spray as an adjunct in patients undergoing surgical pleurodesis

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BACKGROUND

Generation of pleural inflammation (pleurodesis) to prevent recurrence for pneumothoraces is established. It is performed by mechanically abrading or chemically irritating the pleurae during video-assisted thoracoscopic surgery (VATS). Regardless of method, patients experience significant chest wall pain that may impede full lung expansion because of a reluctance to cough or deep breathe. The use of the local anaesthetic ropivacaine (Naropin®, Astra Zeneca, 15 Stanhope Gate, UK) insufflated as a spray into the pleural cavity under vision has been routinely used by the senior authors with good analgesic effect. The technique has not been previously described.

TECHNIQUE

Following isolation of the lung and insertion of a VATS port, the pleural cavity and deflated lung are inspected. Typically, 10 ml ropivacaine 7.5 mg/ml, an amide local anaesthetic with less cardiotoxic effects than bupivacaine, is prepared. It is delivered into the pleural cavity in a Clerf-spray device (StorzMedical, AMC House, Park Royal, London, UK; Fig. 1). Insufflation is achieved by connecting the device to a high-volume, low-pressure device. The spray is directed over the inner chest-wall, mediastinal and diaphragmatic surfaces at the beginning of the procedure. The pleurodesis is performed after 10 min based on data from ropivacaine in peripheral nerve block studies.^{1–3}

Figure 1 Assembled spray device that can be easily inserted and directed through a VATS port.

DISCUSSION

The technique provides significant analgesic effects lasting up to 15 h. In addition, patients receive local anaesthetic infiltration to VATS port sites together with local anaesthetic intercostal nerve blocks. Patients also receive regular paracetamol-based enteral analgesia supplemented by intravenous opioid patient controlled analgesia. Audit of pain intensity scores and opioid consumption demonstrate significant reduction in both since the introduction of the technique.

References

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