Epidural analgesia/anaesthesia versus systemic intravenous opioid analgesia in the management of blunt thoracic trauma

Report by Richard Parris, *Consultant in Emergency Medicine*

Checked by Barbara Scobie, *ST3 in Emergency Medicine*

Royal Bolton Hospital, UK

doi: 10.1136/emj.2007.054999

Abstract

A short cut review was carried out to establish whether an epidural infusion provided any advantage over intravenous analgesia in the management of blunt thoracic trauma. Only four papers presented evidence to answer the clinical question. The author, date and country of publication, patient group studied, study type, relevant outcomes, results and study weaknesses of this paper are presented in table 2. The clinical bottom line is that epidural analgesia may provide better pain relief, but may not alter clinical outcomes.

Three part question

In a [patient with blunt thoracic injury] is an [epidural infusion rather than intravenous administration of opioids] [superior in relieving pain or reducing complications] from his chest wall trauma?

Clinical scenario

A 65-year-old pedestrian involved in a road traffic accident has sustained four fractured ribs and has a small area of contused lung noted on the chest x ray. You wonder whether placement of an epidural catheter and infusion of opioid or local anaesthetic agents offers any benefit over intravenous opioid analgesics (by intermittent bolus or patient controlled analgesia) in relieving the patient's pain or reducing complications from his injury.

Search strategy

Medline: [rib fracture.exp OR thoracic injuries.exp] AND [injections, epidural exp OR analgesic epidural exp]

Embase: [Thorax blunt trauma OR thorax injury OR rib fracture] AND [epidural anaesthesia OR thorax epidural]

Cochrane: Thoracic trauma

Search outcome

Medline produced 56 papers, EMBASE 103, of which four were relevant and of sufficient quality (table 2).

Comments

The limited quantity and quality of evidence illustrates the difficulties in studying this patient group and determining the most relevant outcomes. A significant number of patients will be excluded due to the presence of contraindications to epidural analgesia or to physician concerns that epidural analgesia may prevent continued assessment of the multiply injured patient. All four studies looked at slightly different patient groups, different treatment regimens and outcomes with consistently poor reporting of timing of placement of epidural catheters and administration of intravenous analgesics. Despite these limitations, the evidence hints that epidural analgesia/anaesthesia is superior to intravenous analgesia. However, it is very difficult to be confident that epidural analgesia/anaesthesia offers superior

pain relief and that this effect is translated into improved clinical outcomes with no significant side effects.

► CLINICAL BOTTOM LINE

On limited evidence from moderate quality studies, epidural analgesia/anaesthesia offers some benefits over intravenous analgesia but further studies are needed to strengthen this conclusion.

Bulger EM, Edwards T, Klotz P, *et al.* Epidural analgesia improves outcome after multiple rib fractures. *Surgery* 2004;136:426–30.

Moon MR, Luchette FA, Gibson SW, *et al.* Prospective randomised comparison of epidural versus parenteral opioid analgesia in thoracic trauma. *Ann Surg* 1999;229:684–91.

Mackenzie RC, Karagianes TG, Hoyt DB, *et al.* Prospective evaluation of epidural and intravenous administration of fentanyl for pain control and restoration of ventilatory function following multiple rib fractures. *J Trauma* 1991;31:443–9.

Ullman DA, Fortune JB, Greenhouse BB, *et al.* The treatment of patients with multiple rib fractures using continuous thoracic epidural narcotic infusion. *Reg Anesth* 1989;14:43–7.

Weather dependent nasal erythema in reindeer (Rangifer tarandus)

Report by Stewart Teece and Bernard A Foëx, *Santa's little helpers*

Checked by Kevin Mackway-Jones, *Professor of all things jolly*

Emergency Department, Manchester Royal Infirmary, UK

doi: 10.1136/emj.2007.055004

A short cut review was carried out to establish whether nasal erythema in a reindeer might be a useful navigational aid on Christmas Eve. From a search of nine papers, five presented evidence relevant to the question. The author, date and country of publication, "subjects" studied, study type, relevant outcomes, results and study weaknesses of these papers are presented in table 3. The clinical bottom line is that a reindeer with a red nose at rest at the North Pole would not inspire confidence.

Three part question

[During inclement weather, especially low temperature and fog] is [nasal erythema in reindeer (mythical or otherwise)] a [good indicator of fitness for 24 h transglobal navigation and travel]?

Clinical scenario

On Christmas Eve you intend to circumnavigate the globe stopping at every household containing a child in the space of one night using reindeer as your means of propulsion. However, it is a bit misty out and you fear this will make the task a little bit tricky: some sort of navigational aid would be helpful. You notice one of the reindeer has a very shiny red nose (you might even say it glows). All of the other reindeer are laughing and calling it names but you wonder whether this might be the answer to your navigational problems.

Search strategy

Medline 1950–September 2007 using the OVID interface.(exp Reindeer/or rangifer tarandus.mp. OR reindeer.af.) AND [(exp nose/or exp rhinophyma/or exp rhinitis/OR (nose or rhinophyma or rhinitis).af. OR (snout or snorter or conk or neb or schnoz or hooter).af.)] no LIMITS.

Wikipedia: red-nosed reindeer.

Table 2

Author, date, country	Patient group	Study type	Outcomes	Key results	Study weaknesses
Bulger <i>et al</i> , 2004, USA	46 patients >18 years of age with >3 rib fractures randomised to thoracic epidural (n=22) (bupivacaine, morphine or fentanyl) or systemic opioids (n=24) (morphine, hydromorphone and fentanyl) (patient controlled analgesia (PCA), or nurse administered if patient unable) (n=24). Excluded if had spinal injury, brain or spinal cord injury, altered mental state, unstable pelvic fracture, vascular instability. Also excluded if pain controlled with oral opioids or anti-inflammatory medication. Epidural consisted of bupivacaine, morphine and fentanyl.	Prospective non-blinded block randomised over 45 months	Primary end point was incidence of pneumonia as defined by Center for Disease Control. Duration of mechanical ventilation. Length of stay (LOS) in hospital and intensive care unit (ICU). Mortality. Complications	No significant differences in injury severity score (ISS) between groups but non-significant increase in numbers with flail chest, pulmonary contusions and chest tubes in epidural group. Significant difference in the development of pneumonia in epidural group vs systemic opioid group only if stratified for presence of additional pulmonary injury (OR 6.0, 95% CI 1 to 35; p=0.05) Significant increase in duration of ventilation for systemic opioid group IRR (incident rate ratio) 2.0 (95% CI 1.6 to 2.6 p<0.001) if groups stratified according to presence of pulmonary contusion. No difference in mortality, hospital length of stay (LOS) or ICU LOS or complications.	Small numbers. Non-blinded. No sample size calculation. 408 patients initially eligible but epidural was contraindicated in 282, and 80 refused consent. No details of timing of insertion of epidural or setting up of PCA or doses given. 3 patients in each group crossed over
Moon <i>et al</i> , 1999, USA	34 patients with blunt thoracic trauma (rib fractures, sternal fractures, flail chest, pulmonary contusion) randomly assigned either to thoracic epidural infusion of bupivacaine/morphine or morphine PCA device. Excluded if had contraindication to epidural catheter placement, Glasgow Coma Score <15, morbid obesity, pregnancy, labile blood pressure requiring vasopressors	Prospective non-blinded block randomised study over 19 months	10 point verbal rating pain scale performed at rest, on deep inspiration and movement. Pulmonary function tests including tidal volume (TV), forced expiratory volume (FEV) and maximal inspiratory force (MIF)	Significant reduction of pain scores on day 1 (5.8 vs 7.4) and day 3 (3.8 vs 6.2 (p<0.05) favouring the epidural group. Significant improvement in TV (590 ml vs 327 ml) and MIF (48 cmH ₂ O vs 34 cmH ₂ O favouring epidural group by day 3. No significant differences in FEV on any day between groups. Non-significant increase in LOS in epidural group	High patient withdrawal rate (10/34). Small numbers. No complications recorded. Results often shown graphically: values can only be estimated from graphs, or not put in at all. Study duration was only 3 days. No information on timing of epidurals or setting up of PCA devices.
Mackersie <i>et al</i> , 1991, USA	32 patients recruited with: -3 or more rib fractures; -2 or more rib fractures with pulmonary contusion; -flail chest/sternum; -two or more rib fractures with exploratory laparotomy. Randomly assigned to physician controlled intravenous fentanyl analgesia vs fentanyl epidural analgesia sited in lumbar area. Excluded if age <18, pregnancy, substance abuse, psychiatric disorder, spinal injury, chronic pain, particularly painful limb injury	Prospective block randomised study over 36 months	10 point VAS pain scores. Pulmonary function testing. LOS. Complications	Non-significant difference in mean time to initiation of analgesia for epidural and intravenous groups (7.9±7.0 h vs 6.9±6.7 h respectively). Significant increases for both epidural and intravenous groups in maximum inspiratory pressures (MIP) (17±20 and 5.3±19 cmH ₂ O, respectively) and vital capacity (VC) (5.1±6.5 ml/kg and 2.8±4.5 ml/kg, respectively) compared to pre-analgesia level. Significant increase in PaCO ₂ (5.6±4.2 torr) and decrease of PaO ₂ (-19±14 torr) with intravenous analgesia. Significant decrease in pain scores in both epidural and intravenous groups at rest (-32±24 and -27±27, respectively) and on coughing/deep breathing (-42±25 and -25±26, respectively).	Small unblinded study. Analgesia controlled by physician, not patient. No statistical analysis of complications carried out. Groups matched for LOS, number of rib fractures and ISS
Ullman <i>et al</i> , 1989, USA	28 consecutive patients with multiple rib fractures randomly assigned to thoracic epidural opioid analgesia (n=15) within 72 h or intravenous morphine (n=13). Patients had to have significant pain—excluded if pain only on coughing or deep inspiration. Excluded if patient had head injury	Prospective, non-blinded randomised study over 2 years.	LOS in ICU and hospital. Duration of ventilation. Need for tracheostomy	Epidural group had significant reduction in time on ICU (5.93±1.44 days vs 18.69±5.25 days, p<0.02). Epidural group had shorter hospital LOS (14.85±2.21 days vs 47.69±14.67 days, p<0.03). Epidural group had significantly less time ventilated (3.07±1.35 days vs 18.23±8.12 days, p<0.05). Epidural group had a lower incidence of tracheostomy (6.7±6.7% vs 38.5±14.0%, p<0.05)	Small study in select ICU population. Did indicate timing of placement of epidural catheter. Unblinded. Little information about other injuries though non-epidural group had a non-significantly higher ISS