AN EVIDENCE BASED DEPARTMENTAL GUIDELINE FOR PROVISION OF REGIONAL ANAESTHESIA IN BREAST SURGERY

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Background

Regional anaesthesia (RA) in breast surgery (BS) reduces post-operative^{1,2,3} and chronic pain.⁴ However, the possibility of reduced risk of malignant recurrence^{5,6} massively furthers its role in Oncoplastic BS and the importance of the Regional Anaesthetist.

The neuroendocrine response RA attenuates has multiple pro-malignant effects including depression of cell-mediated immunity, reducing tumour related anti-angiogenic factors and increasing proangiogenic factors.⁷ Additionally, opioids inhibit cellular and humoral immune function, increase angiogenesis and promote breast tumour growth in rodents. A large randomised-control trial assessing if the aforementioned effects of RA translate into reduced long-term recurrence⁷ is due to publish its findings imminently.

Against this background we devised a guideline to increase and standardise the use of RA in oncological BS.

Method

Google Scholar provided the basis of a literature search. All local Surgeons and Anaesthetists undertaking BS were asked their opinions on RA in BS and their preferred modality thereof. The guideline is thus both evidence based and agreeable to relevant parties.

Guideline Summary

In all malignant BS, a block should be performed and this block should precede surgery. On account of its simplicity,⁸ superior efficacy,^{9,10} low complication rate and local favour, PECSII should be the block of choice with an additional PECSI subject to Surgeon's agreement. For axillary dissection, Serratus Anterior block can be offered subject to Surgeon's agreement. Paravertebral and Intrapleural blocks are valid alternatives if PECSI&II are not possible.

Conclusion

Pain reduction alone justifies promotion and standardisation of RA in BS but if oncological benefit is proven, widespread deployment is essential and the status of RA is appropriately elevated.

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