



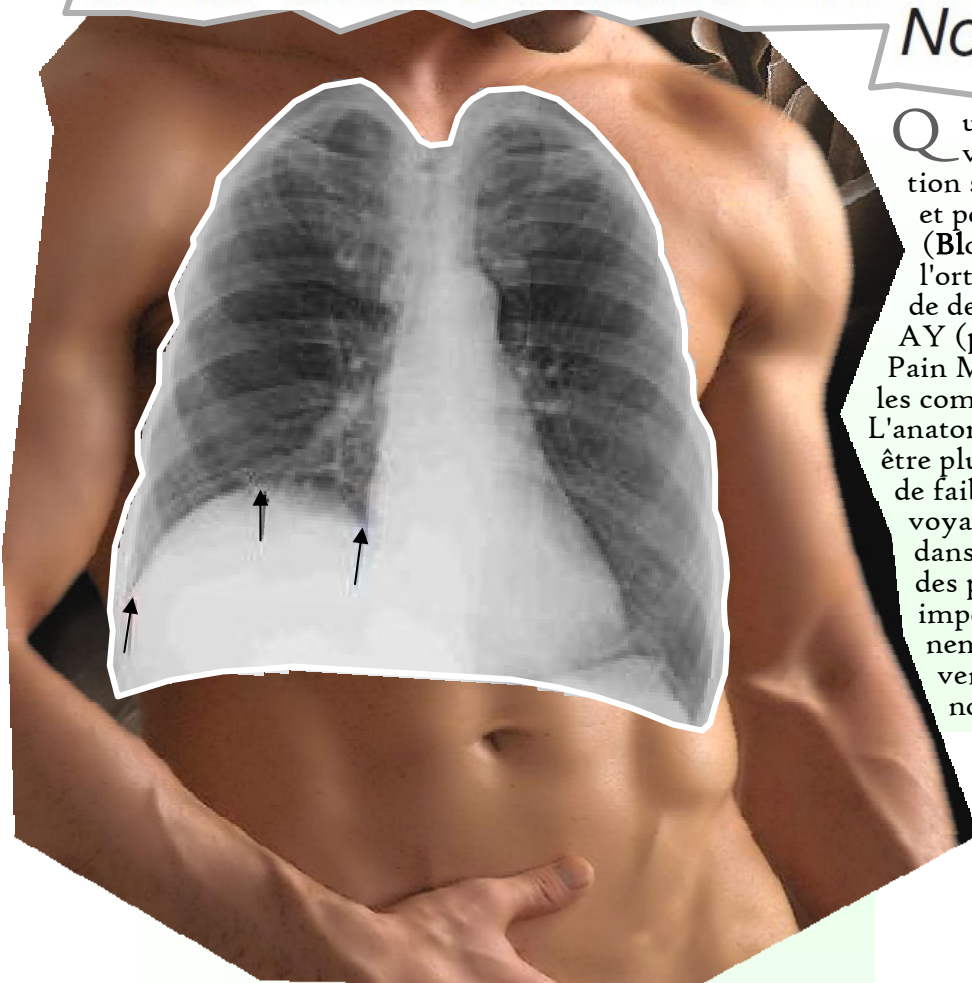
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Anesthésie

Anesth Weekly

Nr 321 - 04 sept 2013

Phrenic Nerve Function after Interscalene Block Revisited Now, the Long View



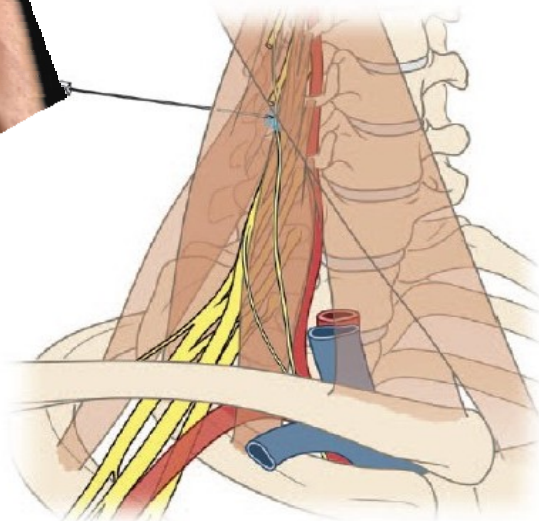
Que dire à ce bel éphèbe qui revient vous voir quelques mois après son intervention sur les tendons de sa coiffe des rotateurs et pour laquelle il a 'bénéficié' d'un B.I.S. (Bloc Interscalénique) ? Si vous faites de l'orthopédie, je vous recommande la lecture de deux papiers qui viennent de paraître dans AY (plus celui de Pakala dans Reg Anesth Pain Med 2013: 239) qui attirent l'attention sur les complications du B.I.S., à moyen terme. L'anatomie du nerf phrénique le prédispose à être plus facilement endommagé. C'est un nerf de faible diamètre dont une longue portion voyage à la surface du muscle scalène. Or, dans l'article de Kaufman et al. on voit que des phénomènes inflammatoires ont un rôle important dans l'apparition du dysfonctionnement du nerf phrénique. Lors de l'intervention de réparation, les chirurgiens ont noté la présence d'adhérences, un épaïs-

sisement des fascias entourant le nerf ainsi que des modifications vasculaires. Plusieurs études récentes ont attiré l'attention sur les complications aiguës et à plus long terme du B.I.S. Dans son service à New York, Pakala rapporte 9 cas de parésie permanente soit 1 sur 2.069 blocs. Notez que la paralysie unilatérale est asymptomatique dans 55% des cas.

MESSAGE

- Savoir: - que ce type de complication existe.
- qu'il faut donc prévenir les patients !
- enfin, qu'une solution chirurgicale est efficace dans près de 70% des cas (expérience de Kaufman et al.)

Q.H. HOGAN - EDITORIAL. ANESTHESIOLOGY 2013; 119(2):250
M.R. KAUFMAN, A. I. ELKWOOD, M.I. ROSE, T. P.ATEL, R. ASHINOFF, R. FIELDS, D. BROWN - SURGICAL TREATMENT OF PERMANENT DIAPHRAGM PARALYSIS AFTER INTERSCALENIC NERVE BLOCK FOR SHOULDER SURGERY. ANESTHESIOLOGY 2013; 119: 250-2.
PAKALA S.R. ET AL. - CERVICAL SPINE DISEASE IS A RISK FACTOR FOR PERSISTENT PHRENIC NERVE PARESIS FOLLOWING INTERSCALENIC NERVE BLOCK. REG ANESTH 2013; 38:239-42



“The anatomy of the phrenic nerve may particularly predispose it to damage from the inflammatory consequences of myotoxicity [from injected local anesthetic] ...”

ÂGE

I.R.C

DOSAGES ?

LE COIN DU
CLINICIEN

DRUG DOSING,
ELDERLY PATIENTS
CHRONIC RENAL DISEASE

J. LASSITER, W. BENNETT
CLIN GERIATR MED 2013; 29: 657-705

Contenu Index Chercher

Contenu

- Introduction
- Approche globale
- Monitoring thérapeutique
- Dosages par classes de médicaments
 - Antibiotiques
 - Morphiniques et leurs antatagonistes
 - Antihypertenseurs et autres agents cardiovasculaires
 - Diurétiques
 - Endocrino et agents métaboliques
 - Agents gastro-intestinaux
 - Agents neurologiques, anticonvulsivants & parkinson
 - antipsychotiques
 - Agents pour le rhumatisme
 - Sédatifs
 - Divers: cortocôides & anticoagulants
- Références

Je ne sais pas ce qu'il en est pour vous, mais en ce qui me concerne, à part pour les grands classiques, j'ai quelques difficultés à me souvenir parfaitement des adaptations de dosages à appliquer aux médicaments, en cas d'insuffisance rénale chronique.

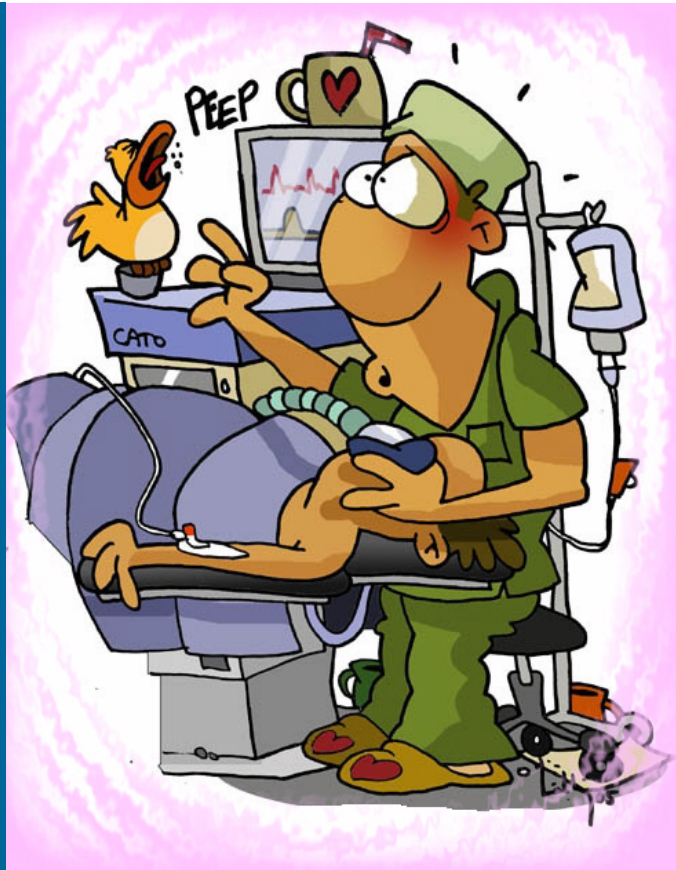
Il y a quelques semaines, au cours d'une lecture 'éclectique', je suis tombé sur un très bel article des 'Clinics in Geriatric Medicine' par Jessica Lessiter et William Bennett, une pharmacienne et un néphrologue qui travaillent à Portland dans l'Oregon. Ils ont, patiemment, colligé les données pharmacocinétiques de beaucoup de molécules que nous avons dans notre armamentarium quotidien.

Pour CHAQUE MÉDICAMENT, ils donnent, dans un tableau, le dosage habituel, le pourcentage excrété par les reins, la réduction de dosage à appliquer en fonction de la GFR (Filtration Glomérulaire Rénale) plus un commentaire sur la toxicité, les interactions ou un aspect particulier.

AVEC LA PERMISSION DES AUTEURS,
JE VOUS AI CONCOCTÉ UNE PETIT SITE (DONT VOUS
TROUVEZ L'ADRESSE EN HAUT DE PAGE).
CLIQUEZ SUR UNE CLASSE DE MÉDICAMENTS POUR
OUVRIR LA LISTE DES MOLÉCULES SPÉCIFIQUES



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"... de ne pas chercher à
être le plus savant;
Ce n'est pas ce qu'on lit
sans choix et sans ordre
qui nourrit et fortifie,
c'est ce que l'on digère.
Jean-Marie Caillaud
1765*1820

Human resources

I have been fortunate to serve in senior leadership in perioperative services in all types of facilities, including university settings, community hospitals, and for-profit and not-for-profit facilities. What I have learned has served me well, and I hope will serve as a guide for others:

- **Always base your decision on what is right for the patient.** This will result in what is best for the patient, and your decision will be solid and defensible.
- **Live by your values and rules.** Walk the talk in all situations, demonstrating to staff and physicians your integrity and what you believe to be the patient's best interests.
- **When in doubt, don't.** If you are uncomfortable in your gut, take no action. As a director, I made a serious mistake by not listening to my intuition.
- **Take time to make your decisions.** Think through the pros and cons. Be sure you can live with your decision.
- **Set high expectations for your staff and leaders.** Communicate in writing and orally. Staff members like to be challenged and usually rise to the occasion.
- **Integrity and relationships are the 2 most important factors in your success as a leader.** Build relationships with other senior leaders beyond the OR doors. When introducing a change or an initiative requiring support from surgeons, do your politicking outside of the meeting room. Have lunch or meet with them in their office to introduce



Beverly A. Peratino,
MS, RN, CNOR

- them to the initiative you need their support for, and tell them why you need it.
- **Develop time management skills** that maximize your productivity. You need to be available to staff and physicians but not at the cost of your schedule. Manage your schedule and stick to it.
 - **Develop relationships with peers** outside of nursing. They have a different business perspective that can be invaluable.
 - **Promote your departmental activities to the rest of the hospital.** Take every opportunity to let people know what is going on behind the doors of the OR.
 - **Never surprise your boss.** Always keep your superiors in the loop about personnel, physician, and operational changes. This way, any differences can be worked out between the 2 of you, and the boss will have your back.
 - **One of the best ways to increase business is to develop relationships with surgeons' office managers and schedulers.** A quarterly breakfast to introduce my staff and to hear their concerns had a significant impact. A box of cookies to each surgeon's office was also appreciated.
 - **Document all encounters with staff.** I always kept duplicate chronological notes and wrote a summary of what an employee

and I discussed—both positive and negative. We both signed the form, and they left with their copy.

- **When making a change with staff, plant the seeds about the change and then form a sub-taskforce to develop recommendations for how the change might be implemented.**
- **Always follow through on what you have committed.** Failure to do so will result in loss of credibility and respect.
- **Tell people what you need** and want. If they don't know, there is no way they can help you.
- **Encourage your staff to attain their next higher level of education—BSN, MSN, or MS.**
- **Encourage staff to sit for the CNOR exam.** When they have successfully completed it, they will have a stronger self-image of themselves as perioperative nurses.
- **Celebrate the success of all certified staff** with a wall of excellence containing their pictures and a plate indicating their certification and date achieved.
- **Provide cookies for office staff at special occasions** like secretaries week.
- **Support and be active in your professional association, AORN.** Staff will listen and follow your lead.
- **Balance work and home life.** If you are not energized and recharged, it is difficult to give to others.

—Beverly A. Peratino, MS, RN, CNOR, a perioperative leader for 25 years, is president of Surgical Services Solutions in Greeley, Colorado.

I have been a nurse for 43 years, and I spent many of those years in management. I have found that the ability to be authentic has served me well in all areas of practice. First, you must be honest 100% of the time and be true to yourself, making sure that your actions match your words.