

Comparative Study of Different Doses of Dexmedetomidine as an Adjuvant to Intrathecal Hyperbaric Bupivacaine in Lower Limb Orthopaedic Surgeries

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Citation this Article: Dr. Jogendra Singh Rajpurohit, Dr. Anisha Banu, Dr. Pradeep Kumar Mulewa, “Comparative Study of Different Doses of Dexmedetomidine as an Adjuvant to Intrathecal Hyperbaric Bupivacaine in Lower Limb Orthopaedic Surgeries”, IJMSIR- February - 2021, Vol – 6, Issue - 1, P. No. 22 – 25.

Type of Publication: Original Research Article

Conflicts of Interest: Nil

Abstract

Background: To study the compare the effect of different doses of dexmedetomidine as an adjuvant to intrathecal hyperbaric bupivacaine in lower limb orthopaedic surgeries

Methods: A prospective randomized double blind study was conducted with 150 consenting patients of ASA grade I and II, scheduled for lower limb orthopaedic surgeries. Using the lottery method, the patients were randomly allotted into 3 groups, 50 patients in each group. Group A , Group B & Group C. The surgeon, patient and the observing anaesthesiologist were blinded to the patient group.

Results: All the patients achieved modified Bromage scale 3 motor block and there was dose dependent prolongation of motor block in B and C groups. Similarly regression of motor block to modified Bromage 0 was significantly prolonged in group C than

B and A group. Complete recovery of sensory and motor functions was observed in all the patients.

Conclusion: Patients in the groups that received dexmedetomidine had reduced post-operative pain scores and a longer analgesic duration than those who received spinal bupivacaine alone.

Keywords: Lower limb, Dexmedetomidine, Bupivacaine, Intrathecal.

Introduction

Trauma is a major cause of mortality throughout the world. In addition to the cost in lives, productivity, and money, trauma exacts a steep toll on patients in the form of physical suffering and mental anguish. In recent years, major advances have been made in the management of trauma, the end result of which has reduced mortality and enhanced function. One of these areas is pain control. Improved pain management for blunt trauma to the lower extremity has not only led to

increased comfort in trauma patients, but has also been shown to reduce morbidity, early ambulation and improve long-term outcomes.¹

In 1968, Melzack and Wall put forward their ‘gate control theory’ proposing that the spinal cord was a potential target site for modulation of pain signals. This changed our concepts about nociceptive transmission and laid the foundation for further research into dorsal horn opioid pharmacology. This led to the discovery of opioid receptors by Pert and Snyder in 1973 and the subsequent identification of dorsal horn opioid receptors by radioligand techniques in 1977. The first intrathecal administration of opioid in patient was reported by Wang et al, in 1979.²⁻³

Dexmedetomidine is highly selective α_2 adrenergic agonist. Drug has been used as intrathecally as an adjuvant and no neurological side-effect is reported in humans. It also provides stable hemodynamic condition, good quality of intra-operative and prolonged post-operative analgesia with minimal side effects. Intrathecal α_2 receptor agonists are found to have antinociceptive action for both somatic and visceral pain.⁴

Material and method

A prospective randomized double blind study.

Inclusion criteria:

Body weight less than 120 kg

Height was more than 150 cm.

Exclusion criteria

Result

Table 1: Socio-demographic variable

Variable	Group-A	Group-B	Group-C	P-value
Age in Yrs	31.24±9.61	33.21±9.02	31.56±8.69	0.61
Male : Female	31:19	32:18	33:17	0.21
ASA (I:II)	42:8	40:10	41:9	0.36

All demographic variable were comparable.

- Patients with hypotension, coagulation defects, spine abnormalities, heart block, arrhythmias etc.
- Body weight ≥ 120 kg and height ≤ 150 cm.
- Patients on calcium channel blockers, adrenergic receptor blockers, ACE inhibitors.

A prospective randomized double blind study was conducted with 150 consenting patients of ASA grade I and II, scheduled for lower limb orthopaedic surgeries. Using the lottery method, the patients were randomly allotted into 3 groups, 50 patients in each group. Group A , Group B & Group C. The surgeon, patient and the observing anaesthesiologist were blinded to the patient group.

All patients received drug volume of 3 ml containing 2.5 ml (12.5 mg) hyperbaric bupivacaine hydrochloride. The study groups received dexmedetomidine 5 μ g (group B) or 10 μ g (C) diluted to 0.5ml with 0.9% saline, added to bupivacaine in the same syringe. The control group A received an identical volume of 0.9% saline added to bupivacaine.

Data analysis

All data were analyzed by Epi-info software. Student t test and ANOVA test for parametric data. Chi square test for non-parametric data.

Table 2: Out come

Variable	Group-A	Group-B	Group-C	P-value
Time of onset of sensory block	7.23±1.32	8.12±2.13	8.42±2.31	0.23
Time of onset of motor block	9.36 ±3.64	9.62±2.58	9.12±2.43	0.36
Duration of sensory block	101.32 ±16.35	114.23±18.56	145.36±19.56	0.01
Duration of motor block	160.23 ±18.24	196.35±25.36	270.25±23.62	0.01

Post-operative VAS and total analgesic requirement in 24 hours were minimal in group C as compare to B group. All the patients achieved modified Bromage scale 3 motor block and there was dose dependent prolongation of motor block in B and C groups. Similarly regression of motor block to modified Bromage 0 was significantly prolonged in group C than B and A group. Complete recovery of sensory and motor functions was observed in all the patients.

Discussion

Van Tuijl I⁵ added various doses of clonidine (0, 15 or 30 µg) to 5 mg hyperbaric bupivacaine and evaluated their effect on the duration of the motor block, analgesic quality and ability to void. They opined that addition of 15 and 30 µg of clonidine increased the motor block duration by 25 and 34 min, respectively and also resulted in better analgesic quality.

Hutschala D, Mascher H et al⁶ added clonidine to bupivacaine and found that it enhances and prolongs analgesia after brachial plexus block via a local mechanism in healthy volunteers.

Niemi L et al⁷ studied effects of intrathecal clonidine on duration of bupivacaine spinal anesthesia, hemodynamics, and postoperative analgesia in patients undergoing knee arthroscopy and found that intrathecal clonidine significantly prolongs the anesthetic and analgesic effects of bupivacaine. Kalso A(4) reported that as compared to clonidine, the affinity of DXM to [alpha] 2 receptors is ten times greater. Results of our study showed that addition of dexmedetomidine to

bupivacaine although delays onset but, significantly prolongs the duration of sensory and motor block.

Mahmoud M. Al-Mustafa et al⁸ added dexmedetomidine to spinal bupivacaine for urological procedures. He compared 5mcg (Group D 5) and 10 mcg (Group D 10) of dexmedetomidine added to 12.5 mg bupivacaine to bupivacaine 12.5 mg with normal saline (Control group). The author found that the mean time of sensory block to reach T10 dermatome was 4.7±2.0 minute in D10 group, 6.3±2.7 minute in D5 group and 9.5± 3.0 minute in control group. The mean time to reach bromage 3 scales was 10.4±3.4 minute in D10 group, 13.0±3.4 minute in D5 group and 18.0 ± 3.3 minute in control group. Regression time to reach S1 dermatome was 338.9±44.8 minute in D10 group, 277.1±33.2 minute in D5 group and 165.5 ± 32.9 minute in control group. Time to reach bromage 0 was 302.9±36.7 minute in D10 group, 246.4.1±24.7 minute in D5 group and 140.1 ± 32.3 minute in control group. They found that dexmedetomidine has dose dependent effect on onset and regression of sensory and motor block.

Conclusion

Patients in the groups that received dexmedetomidine had reduced post-operative pain scores and a longer analgesic duration than those who received spinal bupivacaine alone.

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