

Preprocedural Checklist: Equally Important for “Pain Procedures” Editorial

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ABSTRACT

Checklists are designed to reduce errors and ensure consistency and completeness in carrying out a duty. It compensates for potential limits of human memory and attention. World Health Organization Surgical Safety Checklist demonstrated significant reductions in both morbidity and mortality with checklist implementation. Surgery checklist and anesthesia checklist are already in use. But any specific globally accepted checklist prior to pain procedure is yet to be found. Here, I suggest an initial structure of a checklist specifically designed for the pain procedures. Modification with time is well expected.

Keywords: Checklist, Guidelines, Pain procedure, Policy.

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American Society of Regional Anesthesia and Pain Medicine published guidelines¹ in 2014 recommending the use of a preprocedural checklist before performing regional blocks. Recently, it has been shown that implementation of a regional anesthesia (RA)-specific preprocedural checklist was associated with a significantly lower incidence of wrong side nerve block procedures.² Although the advices in the checklists^{3,4} are good and may be applied prior to the chronic pain procedures, they do not address all the issues associated with the pain procedures. Technically, RA or nerve blocks may have similarity to the pain procedures, but the expected outcome is almost always different. The easily perceived differences are mentioned here: (1) unlike RA, the pain procedures must have a long-lasting effect except diagnostic blocks. In most patients, interrupting only the pain pathway is not sufficient, and a pain generator must be searched and treated if possible. (2) In the pain procedures, it is almost always a selective sensory or autonomic nerve-targeted procedure. Motor nerves are never touched unless already damaged or extremely necessary in special circumstances like end of life care. (3) In the pain procedures, the injected drug may include steroid or neurolytics like alcohol or phenol. A person on disulfiram therapy for alcohol addiction should not receive alcohol neurolysis. Steroid, however, can cause a different set of complications. A particulate steroid can cause embolization and infarction. (4) A patient with pacemaker poses additional risk if radiofrequency denervation is planned. (5) A diagnostic block, if planned, means that, if necessary, patient is fit to receive the long-lasting treatment thereafter. For diagnostic block, the patient must be in pain or at least reproduce the pain when procedure is performed. (6) Fasting does not seem mandatory for the minor pain procedures, (7) few pain procedures are considered high risk (e.g., spinal cord stimulation). So, antibiotic prophylaxis is usually given. (8) Bowel preparation may be required in specific procedures (e.g., celiac plexus neurolysis under ultrasonography). (9) Anticipating the complete procedure is important. Patient must be able to tolerate the positioning during the whole procedure. If the procedure requires fluoroscopy, pregnancy must be ruled out. (10) The pain procedures are usually done under local anesthesia. Only few high-risk procedures may need general anesthesia or conscious sedation. Apart from applying monitoring devices, in certain cases, the presence of a dedicated anesthesiologist is required.

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(11) In few circumstances, a psychological assessment is necessary prior to the pain procedure (e.g., spinal cord stimulation). (12) It is always beneficial to check the functional status of the special equipment (e.g., radiofrequency machine and cryo machine) prior to starting the pain procedure. (13) Finally, patient should receive the complete postprocedure advice. Expected side effects specific to a certain procedure should have been explained prior to the procedure. Complications, on the contrary, must be ruled out prior to discharge. A discharge certificate must have future course of action, emergency contact information, and other relevant advices.

I present here a summary of my proposed checklist (Table 1). It has three parts and needs to be applied at three areas during the

Table 1: Pain procedure checklist

- (A) At out patient department (OPD)
- Consent
 - Patient on drugs (anticoagulants, oral Hypoglycemic agents (OHA), or for other comorbidities), implanted device, no analgesic for 24 hours if the patient is for diagnostic block
 - Allergy history
 - Need of antibiotic during or before the procedure
 - NIL by mouth is required or not?
 - Bowel preparation is required or not?
 - Anticipate the procedure: consider positioning, local site inspection, review X-ray/computed tomography

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- Postprocedure mobility (whether relative should accompany)
 - In females: pregnancy or lactation
 - Need for anesthesia
 - Complete diagnosis (with comorbidity? Anxiety/depression) and procedure planned
 - Addiction history
- (B) Preprocedure
- Recheck checklist (in OPD)
 - Medicine, equipment, table, recording device functioning/ available or not
 - Check blood sugar, creatinine, prothrombin time (PT), platelet count, bleeding time (BT) if indicated
 - Consider monitor and IV line, preloading
 - Confirm patient name and site/side of injection
 - Bladder empty
 - Jewelry removed
 - Aseptic and antiseptic protocol (mask/cap of doctors, local preparation, and drapping)
- (C) Postprocedure
- Expect side effect (motor power loss, hypotension)
 - Review for complications (unexpected motor loss, etc.)
 - Documentation, advices (restrictions, how to restart the drugs if stopped)
 - Review plan, sick leave

pain procedures. In future, the studies only can confirm or refute a positive impact of this checklist on patient safety.

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