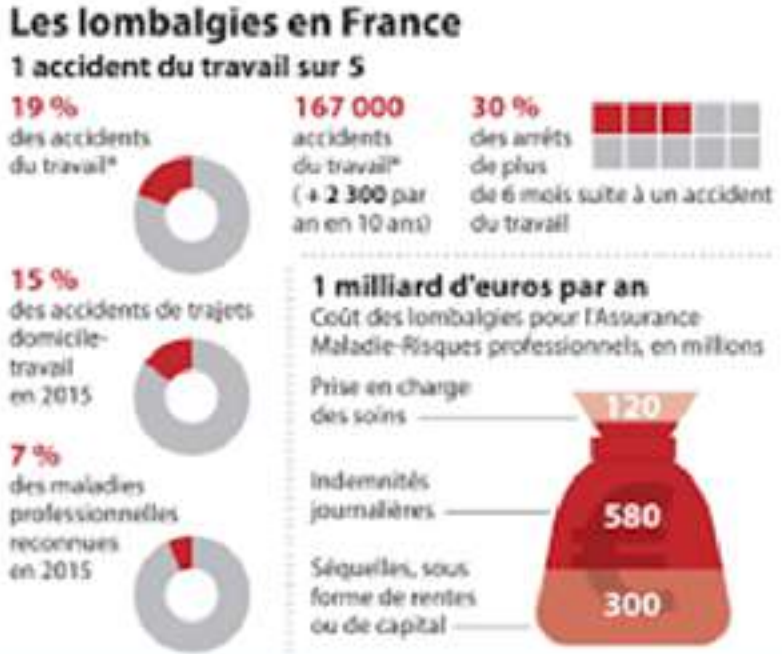
Soirée dos-remis

`ANESTHAU7

PST Sète

La Lombalgie : une pandémie récidivante invalidante



1 arrêt de travail sur cinq

167.000 accidents du travail

Pour l'Assurance-maladie, le coût s'élève à près d'un milliard d'euros par an.

franceinfo: Lombalgie : un coût très élevé pour la Sécu

"*Lors des épisodes de lombalgies aiguës, l'important est de ne pas arrêter les patients. Et si on les arrête, c'est deux jours maximum. Mais par contre, il faut leur donner un traitement immédiatement qui soit efficace (...)* ", explique le Pr François Rannou, rhumatologue à l'hôpital Cochin de Paris.

Le lumbago ou lombalgie

- Lumbago = Lombalgie aigüe (durée < 12sem)
- 70-80 % des adultes au cours de leur vie
- 50 % de récidive
- Guérison spontanée 90 % en 2 à 6 semaines
- 10 % chronicisation

Le traitement est… inefficace

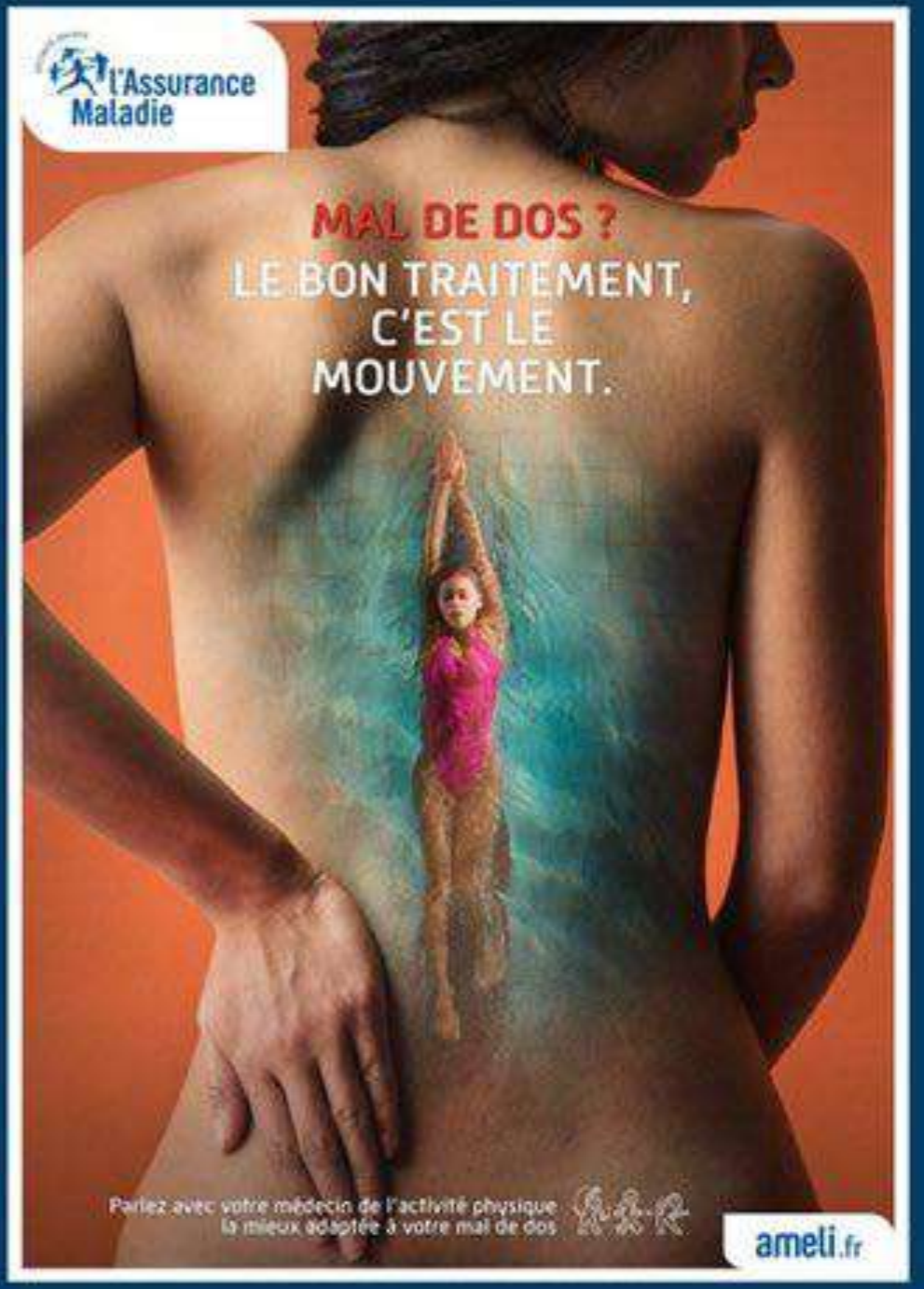
Systemic Pharmacologic Therapies for Low Back Pain: Ann Intern Med. 2017 Apr 4;166(7):480-492.

New evidence found that acetaminophen was ineffective for acute low back pain
Skeletal muscle relaxants are effective for short-term pain relief in acute low back pain but caused sedation.
Systemic corticosteroids do not seem to be effective. Evidence is insufficient to determine the effects of antiseizure medications.
Compared with placebo NSAIDs may be more effective than placebo at improving pain in people with acute low back pain (very low-quality evidence).
For effective interventions, pain relief was small to moderate and generally short-term; improvements in function were generally smaller.

Medications for acute and chronic low back pain: a review of the evidence

The magnitude of benefit is moderate (effect size of 0.5 to 0.8, improvement of 10 to 20 points on a 100-point visual analogue pain scale, or relative risk of 1.25 to 2.00 for the proportion of patients experiencing clinically significant pain relief) Ann Intern Med. 2007


l'Assurance Maladie
MAL DE DOS ?
LE BON TRAITEMENT, C'EST LE MOUVEMENT.
Parlez avec votre médecin de l'activité physique la mieux adaptée à votre mal de dos
ameli.fr


l'Assurance Maladie
MAL DE DOS ?
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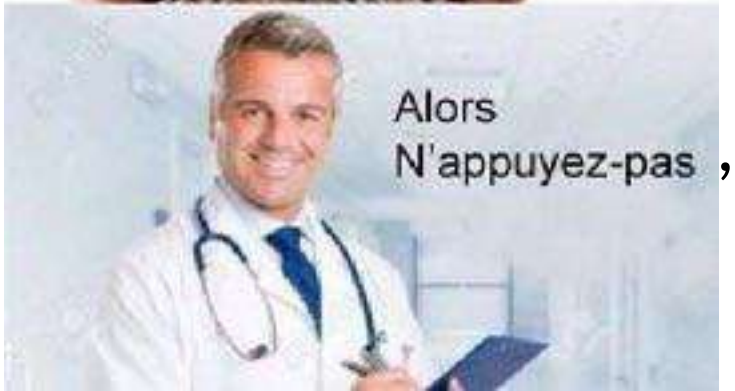
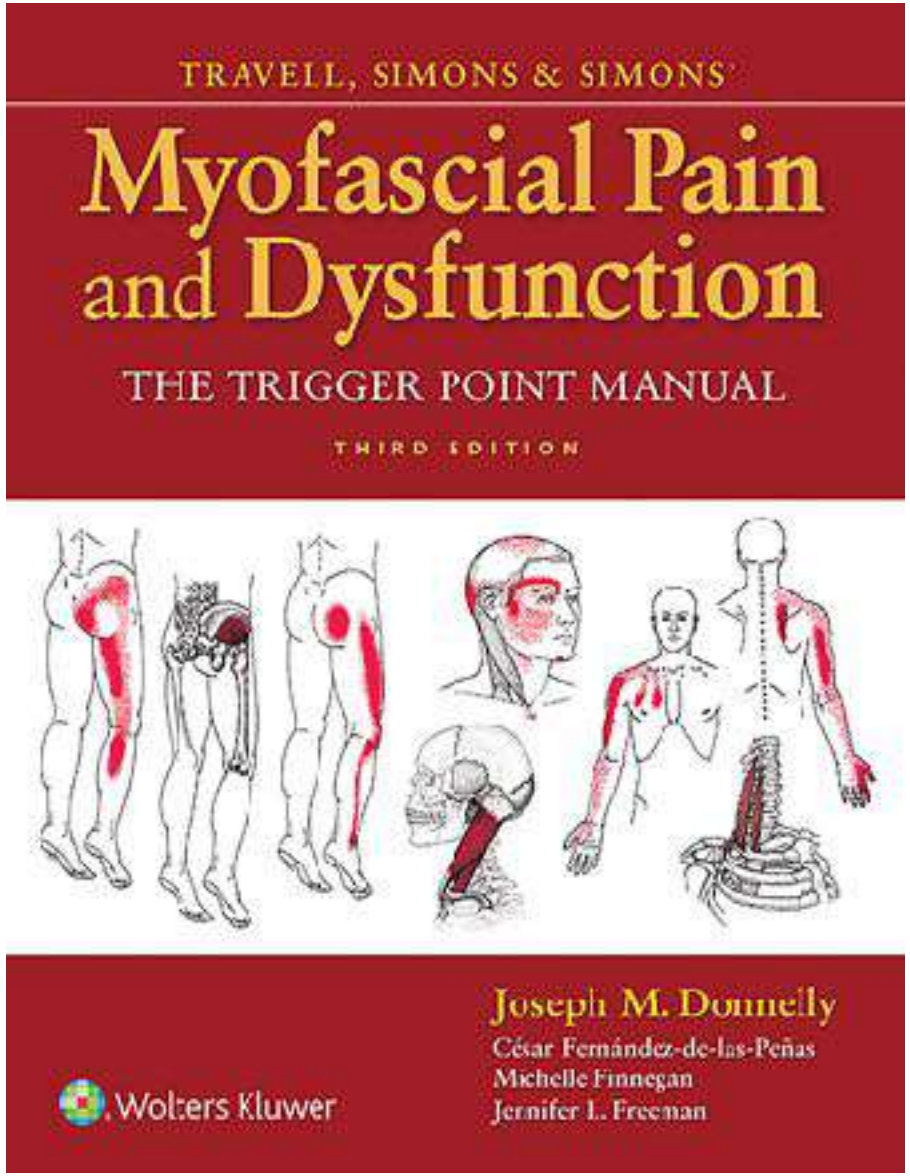
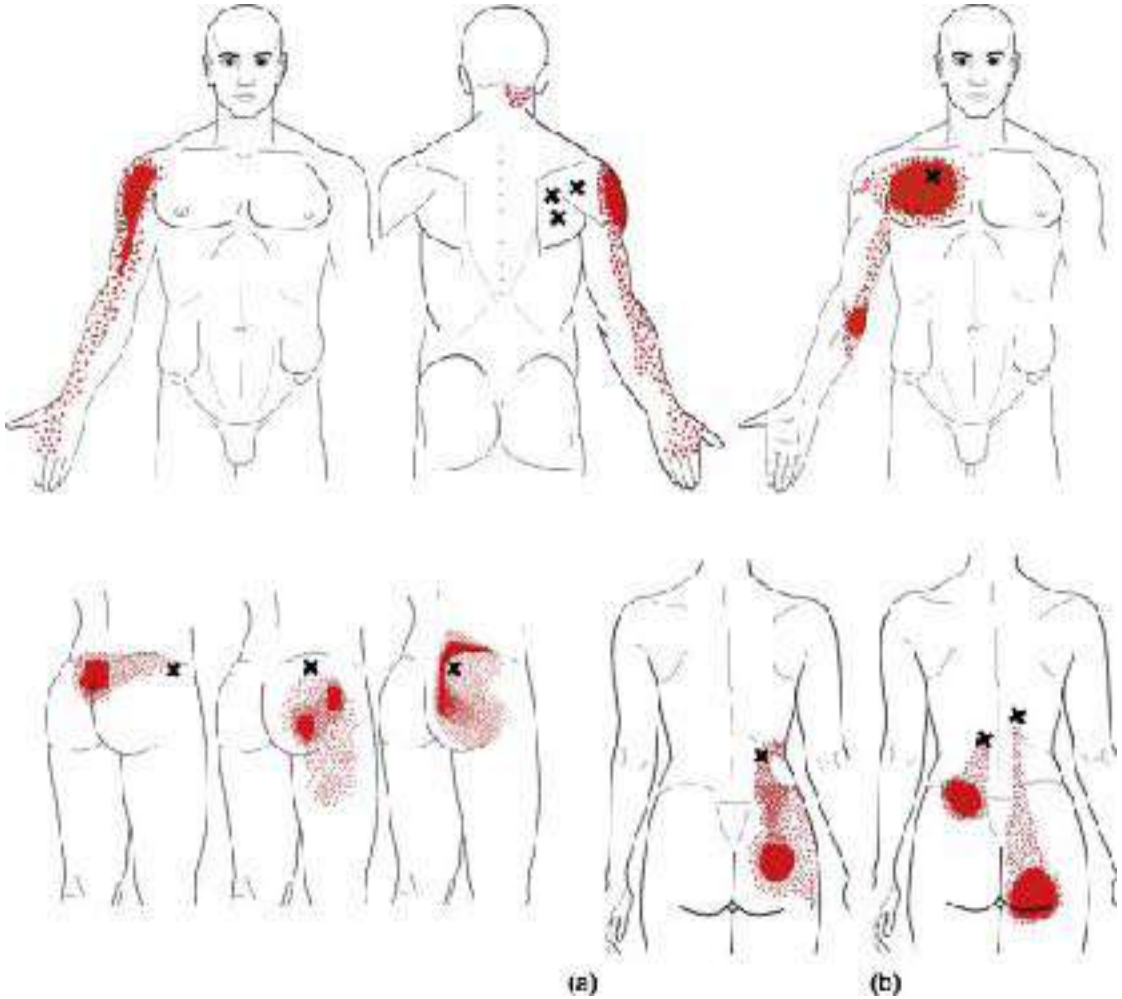
Le concept:



, je vais vous infiltrer

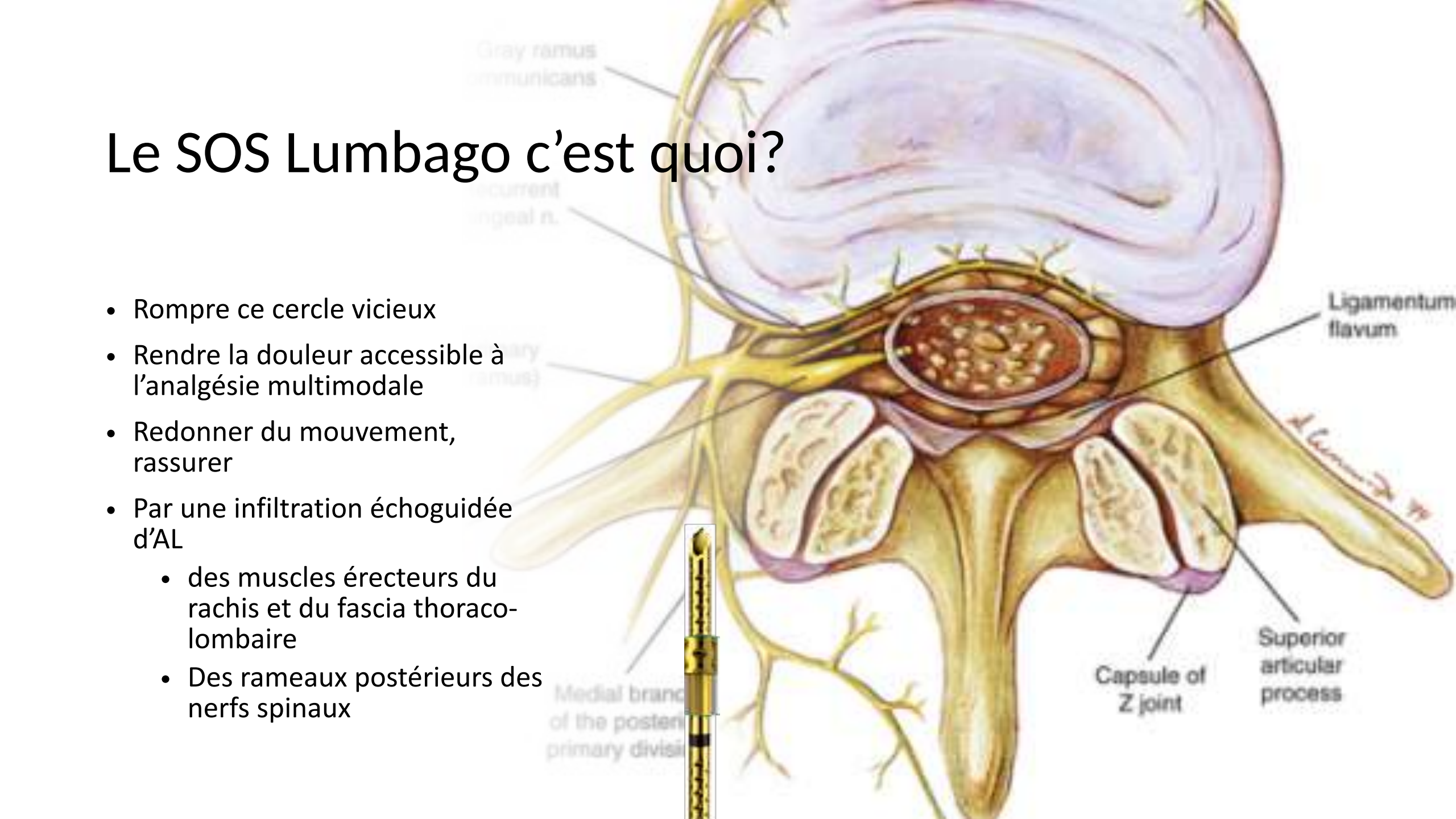
Senator Barry Goldwater told President Kennedy in a letter that he doubted if the president would ever do anything finer for the American people than bringing this remarkable woman to their attention.


TRAVELL, SIMONS & SIMONS
Myofascial Pain and Dysfunction
THE TRIGGER POINT MANUAL
THIRD EDITION
Joseph M. Donnelly
César Fernández-de-las-Peñas
Michelle Finnegan
Jennifer L. Freeman
Wolters Kluwer

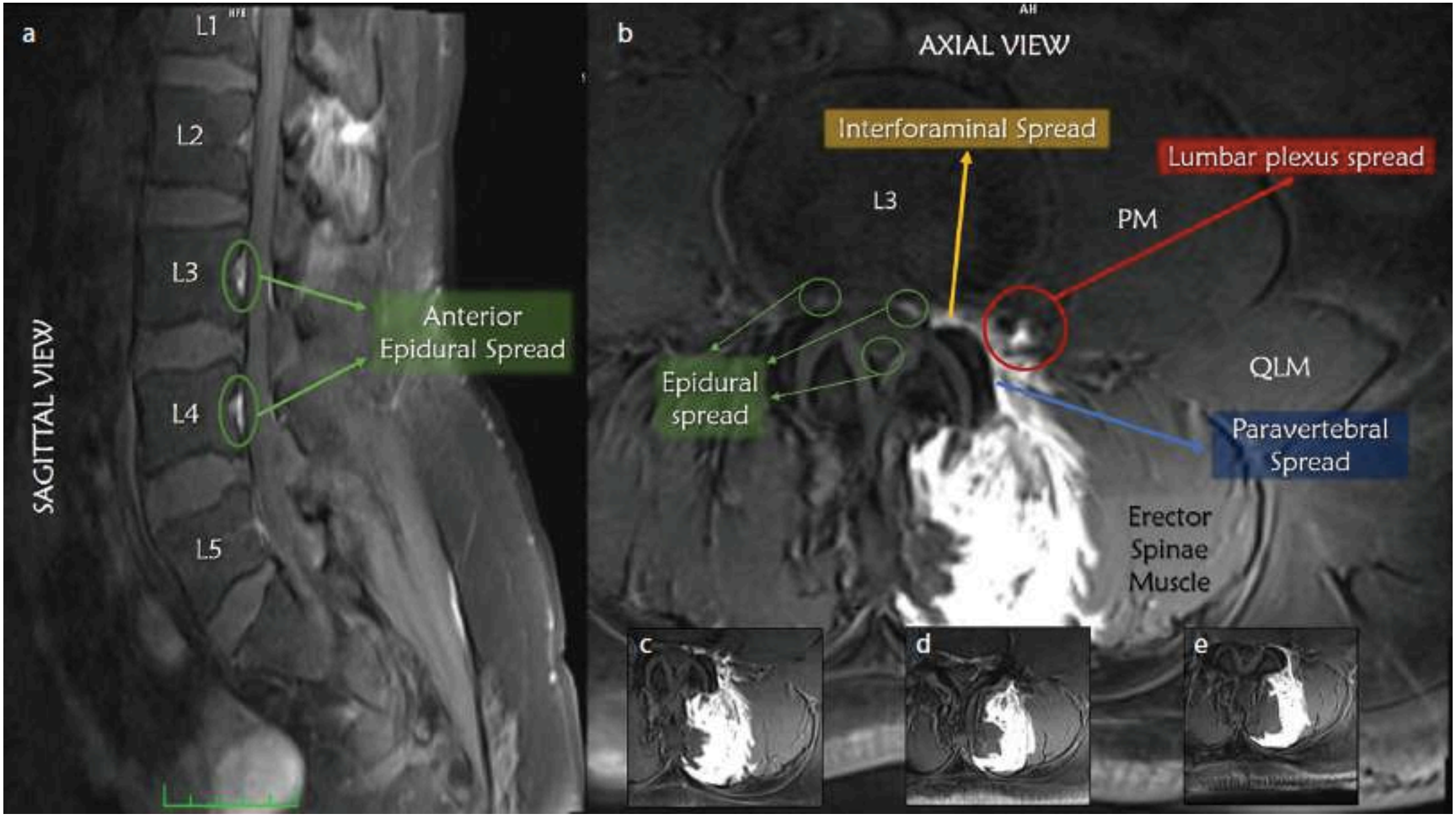

(a)
(b)

Le SOS Lumbago c’est quoi?

- Rompre ce cercle vicieux
- Rendre la douleur accessible à l’analgésie multimodale
- Redonner du mouvement, rassurer
- Par une infiltration échoguidée d’AL
  - des muscles érecteurs du rachis et du fascia thoraco-lombaire
  - Des rameaux postérieurs des nerfs spinaux




SAFETY
FIRST
MAKE THE NEW
GUY DO IT


a
L1
L2
L3
L4
L5
SAGITTAL VIEW
Anterior
Epidural Spread
b
AXIAL VIEW
Interforaminal Spread
Lumbar plexus spread
L3
PM
Epidural
spread
QLM
Paravertebral
Spread
Erector
Spinae
Muscle
c
d
e

Motor block following bilateral ESP block

Journal of Clinical Anesthesia 60 (2020) 23

At the end of the surgery patient was promptly extubated. She reported a complete motor block and anesthesia of the legs. The sensory block level was assessed at T11 level by both pinprick and absence of cold sensation.

Complete motor blockade lasted 7 h while the sensory block solved progressively and completely in 10 h. Patient had full motor and sensory recovery in 10 h and was discharged from hospital after 48 h without further complications.

Ultrasound guided erector spinae plane block as a cause of unintended motor block☆,☆☆

O. Selvi*, S. Tulgar Rev Esp Anestesiol Reanim. 2018;65(10):589–592

guidance at a distance from the spinal cord. Hip flexion was objectively weak (2/5). There was also weakness in knee extension (2/5). The maximum sensory deficit was recorded between T9 and L3 dermatomes, and femoral sensory loss was noted. Her motor strength initially began to return 13 h after surgery, and was fully restored at 16 h, when she was able to walk with support. She required only 1 dose of i.v.

Pubmed: ESPB + acute low back pain

Case Reports > Am J Emerg Med. 2023 Oct;72:223.e1-223.e4.
doi: 10.1016/j.ajem.2023.07.047. Epub 2023 Jul 26.

Ultrasound guided lumbar erector spinae block: A case series on a novel technique for the treatmen acute low Back pain

Drew Silver [1], Kathryn Anderson [1], Dasia Esener [1], Gabriel Rose [2]

Affiliations + expand

PMID: 37524634 DOI: 10.1016/j.ajem.2023.07.047

Abstract

Low back pain is among one of the most common presentations to the emer (ED). Regional anesthesia has recently gained traction as an option for anal especially in the wake of the opioid epidemic. Data on lumbar application of of acute, refractory low back pain in the ED is scarce. We describe a series patients who presented to the ED with severe low back pain refractory to t successfully treated using lumbar ESPB. Lumbar ESPB may be an effectiv rapid analgesia in patients who present with low back pain who may othe for more traditional therapy, such as with opioids or NSAIDs, or who ma despite use of these medications.

> Pain Manag. 2021 Nov;11(8):631-637. doi: 10.2217/pmt-2021-0004. Epub 2021 Jun 9.

Erector spinae plane block: a new option for managing acute axial low back pain in the emergency department

xander J Anshus [1], Jessica Oswald [1]

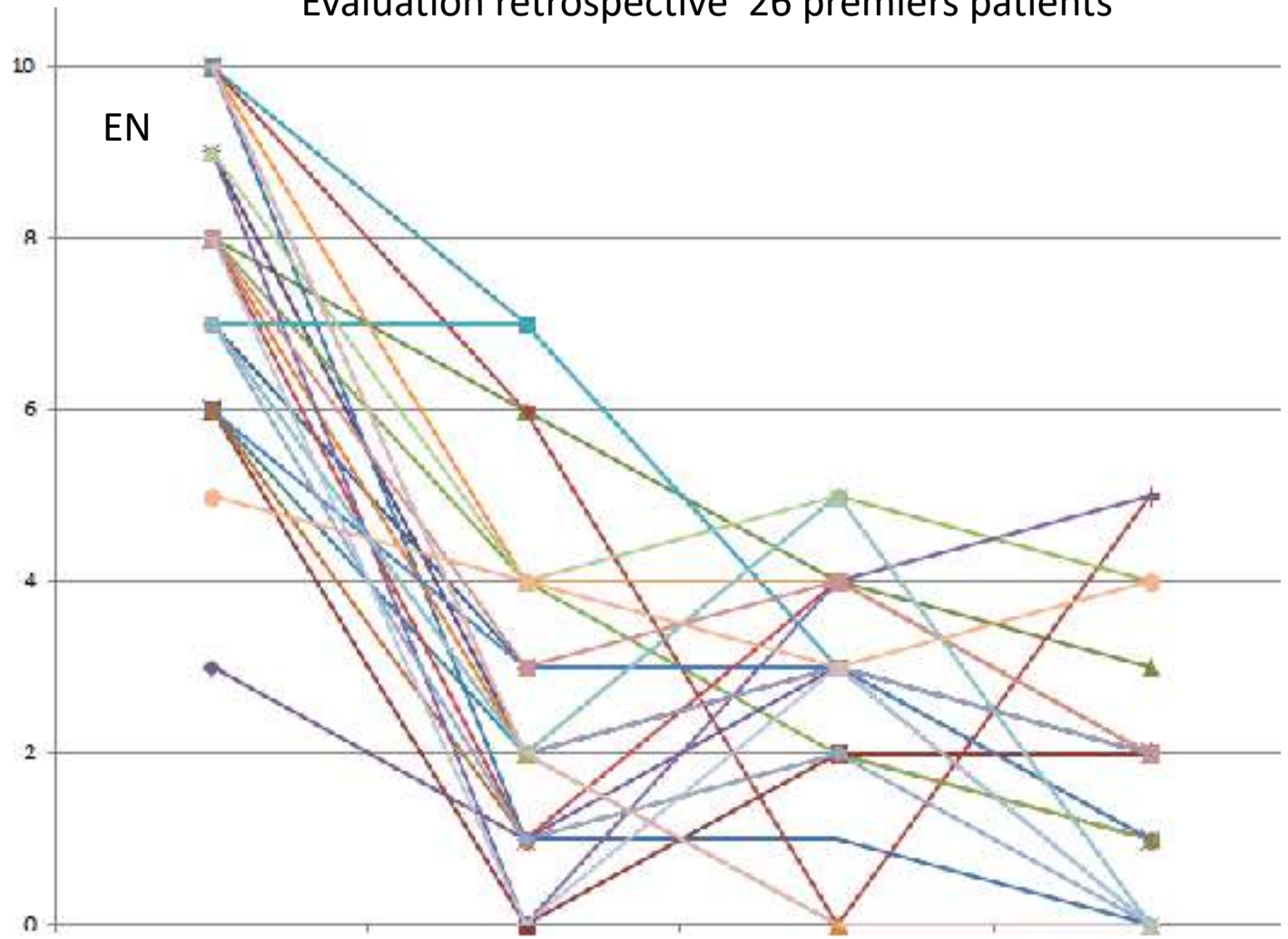
tions + expand

34102865 DOI: 10.2217/pmt-2021-0004

aluate pain and length of stay outcomes in six patients who received an erector spinae k (ESPB) in the emergency department (ED) for low back pain. **Materials & methods:** A eries of six patients who received unilateral or bilateral ESPB after presenting to the ED for te atraumatic axial low back pain. **Results:** The average visual analog scale pain score reduction 81.8%, and length of stay after ESPB was 73.6 min. No postprocedure opiates in the ED or after harge were required. **Conclusion:** The ESPB is a rapid, safe and opiate-sparing option for the tment of acute low back pain.

douleur

Évaluation rétrospective 26 premiers patients

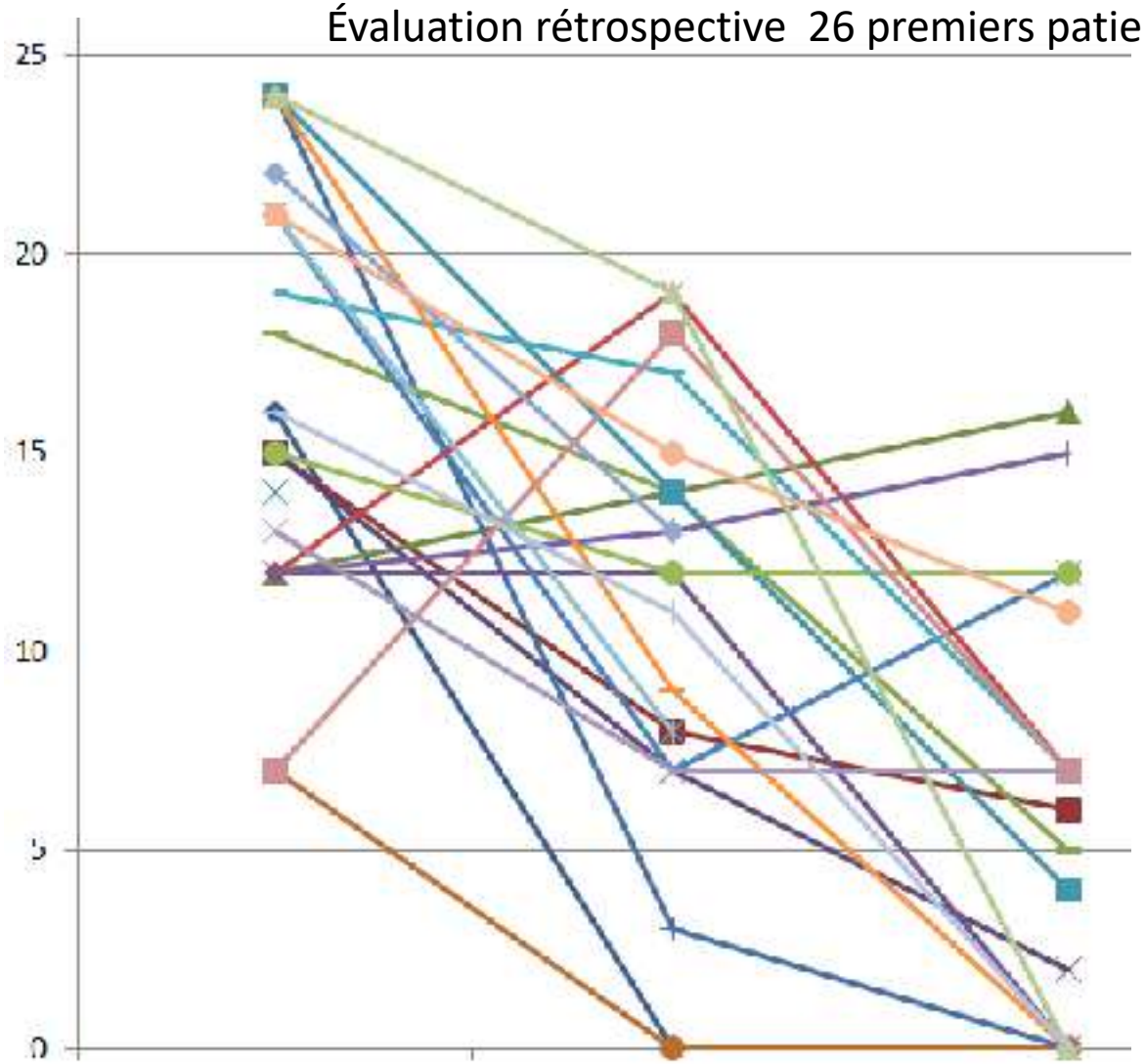


8±2 3±2 4±1 2±1

<0,0001

Évaluation rétrospective 26 premiers patients

EIFEL



18±5 9±5 5±5

<0,004

Conclusion:

- Le bénéfice peut être spectaculaire
- Restaure le mouvement et rend la douleur accessible à l'analgésie multimodale de palier 1
- Le bénéfice sociétal est à évaluer… mais potentiel énorme!
- Un PHRC va débuter (vs Serum physio)
- La technique est simple pour un MAR habitué aux blocs échoguidés
- B/R très favorable