Commentary

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Comparing the Effectiveness of Fascia Iliaca Block with Standard Analgesia in Neck of Femur Fractures in a District General Hospital Emergency Department-A Prospective Study with Review of Literature'

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Analgesia for neck of femur fractures has evolved over the years. An opioid-free or limited approach with opioid is the preferred approach. As highlighted in the article, the use of regional nerve blocks such as Fascia Iliaca Blocks (FIBs) are opioid sparing, this avoids the detrimental effects of opioids. There is much debate if USS guided FIB are superior to the landmark technique. This could perhaps be due to due to the sonographer's expertise in USS imaging which would have an impact on the exact site of infiltration. Through personal experience, the analgesic effect is better established using USS guided technique when compared to landmark technique.

As highlighted in the article, uncontrolled pain has a multiple negative impact on the patient's recovery. The Royal College of Emergency Medicine (RCEM) guidance is for every single patient to undergo FIBs unless there are contra-indications. Although being on anticoagulants such as warfarin or rivaroxaban is not an absolute contraindication if USS guided approach is undertaken, certain trusts avoid this to prevent iatrogenic bleeding. Previously FIBs used to be solely performed by anaesthetists, however there has been a shift to its use in the immediate phase in the Emergency Department. Junior doctors within their first two years of training are now being equipped with the skills to perform this procedure initially utilising the landmark technique. In the more advanced stages of training, ultrasound guided techniques are being utilised. With the ageing population, the prevalence of cognitive impairment in the population will also rise, with this the co-existing morbidities will also rise. With this the incidence of polypharmacy, the effective analgesia that can be provided in addition to the regular prescribed analgesia is somewhat limited.

Through further clinical experience, I have noted that trusts across the country have now implemented dedicated FIB pathways that are part of quality improvement projects. This helps in both maintaining quality control as well as part of regular audit process.

It is also a useful part of a multimodal analgesic strategy that is opioid sparing. It remains to be seen the true impact based on the results of large RCTs comparing cases that undergo compared to standard analgesia.

In the article, although I had mentioned that the RCEM does not have an exact time frame to have the FIB done, it is an RCEM target that patient with severe pain are reassessed within 15 minutes of the initial assessment. Understandably patients with cognitive impairment, communication related problems may not be able to explicitly state their levels of discomfort. In this group of patients, non-verbal scales are used whilst addressing their usual response to pain as highlighted by their careers.

Irrespective of the mode of analgesia that is being implemented, it is vital that analgesic control takes priority including at the time of initial resuscitation. With the extra training that is now available, emergency medicine physicians are better suited to approach with a multimodal opioid sparing strategy from the front door of the hospital.

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