Association of Anaesthetists

Fascia Iliaca blocks and non-physician practitioners

Thursday 23 January 2020

Early administration of a fascia iliaca block is recommended in patients with fractured neck of femur to reduce pain and use of opioid analgesia.[1]

Since the last joint statement from Regional Anaesthesia-UK (RA-UK) and the Association of Anaesthetists in 2013,[2] the use and availability of ultrasound for performance of the fascia iliaca block has increased. This has also led to the development of several ultrasound guided approaches to the fascia iliaca block which are more reliable than the traditional landmark approach.

The ultrasound guided infra-inguinal approach to the fascia iliaca block uses a similar needle insertion point to the landmark approach, distant from neurovascular structures. This approach allows visual confirmation of local anaesthetic spread in the correct anatomical plane, deep to the fascia iliaca.[3]

Physicians are often not immediately available to perform ultrasound guided fascia iliaca blocks at the time of patient arrival to hospital. In order to provide timely access to this beneficial treatment, RA-UK endorses the use of the infra-inguinal ultrasound guided fascia iliaca block by trained non-physician practitioners. This practice must be in the setting of appropriate local training programmes, with strict adherence to clinical governance protocols and regular review of quality and safety.

All patients should receive appropriate monitoring for 30 minutes after administration of a fascia iliaca block to detect signs of local anaesthetic toxicity, and also opioid induced respiratory depression in the setting of previously administered opioid analgesia. [4,5]

We do not endorse the use of the suprainguinal fascia iliaca block by non-physician practitioners due to a higher potential risk of complications including intra-abdominal injury.[6]

References

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Fascia Iliaca Blocks and Non-Physician Practitioners

AAGBI POSITION STATEMENT 2013

The Association of Anaesthetists
of Great Britain & Ireland

RA-UK
Regional Anaesthesia United Kingdom

Fascia Iliaca Blocks and Non-Physician Practitioners

Proximal femoral fractures are often very painful, and the prompt administration of analgesia is both a humanitarian necessity and likely to be associated with improved clinical outcomes. Fascia iliaca block, which has been shown to be more effective than opioids in treating hip fracture pain [1], is a technique that has rightly gained popularity in Accident & Emergency Departments.

Regional Anaesthesia UK (RA-UK), in its 2010 position statement on the performance of local and regional techniques by non-physician practitioners [2], defines *regional anaesthesia* techniques as those that place local anaesthetic "around the major plexuses or identifiable peripheral nerve trunks", and asserts that only appropriately trained physicians should perform these techniques. The AAGBI and RA-UK have agreed that fascia iliaca block can be considered to be a "local anaesthetic " and not a "regional anaesthetic " technique under this definition, because when the correct technique is used, the needle trajectory is not likely to encroach on nerve trunks or major blood vessels (Figure 1). The two organisations have agreed the following statement with regard to fascia iliaca blocks:

> Ideally, appropriately trained physicians should perform fascia iliaca blocks but, in many circumstances, they are not immediately available to administer the blocks. Other registered health professionals who have received appropriate training and are following agreed clinical governance procedures may perform these blocks. This extended role of non-medically qualified personnel should be closely monitored by the hospital's Department of Anaesthesia, and such practices should be subject to regular audit and review.

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References

1. Foss N B, et al. *Anesthesiology* 2007; **106**: 773-8.
2. http://www.ra-uk.org/images/stories/content/RAUK%20Position%20Statement%20June%202010%20FInal.pdf

Figure 1