

LETTERS TO THE EDITOR

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Local anesthetics allergy in pregnancy

We present the case of a pregnant patient with a potential allergy to local anesthetics (LA) that compromised her access to epidural analgesia. Allergic responses to LA are rare but can have fatal consequences.¹ On the other hand, prejudice about the safety of skin testing in pregnancy rules out allergy testing in pregnant women.² In May 2021, we visited a 24-year-old primipara woman at 38 weeks of gestation. The only relevant information was an episode of skin flushing, palpitations and feeling of faintness following the administration of an unknown LA during dental extraction. Result of this, the patient performed specific IgE assays for LA several years ago. IgE for lidocaine and mepivacaine (performed abroad, as in Italy are considered not standardized enough) were low, while those for articaine were in a range that did not exclude allergy to this LA. The case was discussed collegially (anesthetists, allergists, and gynecologists) and it performed an additional skin test to search for any allergy to ropivacaine after acquired an informed consent. The skin prick test (SPT) was completed using the undiluted drug, while Intradermal Test (IDT) was performed using non-irritant dilutions of 1/100 and 1/10 and showed no allergic reaction to ropivacaine 1%. On June 2, the woman was hospitalized during labor. We used Epidural technique for pain management with 0.1% ropivacaine + 0.4 mcg/mL sufentanil. The woman delivered after about five hours without complications. Pain relief is a human right and represents the core of the medical ethic. Scientific developments, as well as cultural attitudes, influence pain management practices for childbirth. The actual or suspected allergy to LA in pregnant women limits the use of loco-regional techniques for both analgesic (labour) and anesthetic (caesarean section) purposes. Maternal and fetal morbidity and mortality increase in case of cesarean section under general anesthesia. The use of alternative methods such as continuous infusion of intravenous remifentanyl does not guarantee the same efficacy and safety. SPT and IDT, according to the guidelines,³ is a valid method to diagnose IgE-mediated allergic disease with suspected drug allergy. It is minimally invasive and inexpensive. Results are immediately accessible and reproducible.⁴ A patch test was not chosen due to the nature of the patient-reported reaction to the unknown LA, most likely

a hypersensitivity reaction of the first type. The adverse effects of allergic studies are remote⁵, but this risk cannot be excluded entirely, especially in susceptible subjects such as pregnant women.⁴ The absence of severe reactions in one patient does not protect us from what can happen to others. To reduce the risk of maternal and fetal complications, we advise carrying out SPT close to the end of pregnancy and in a safe environment, with the presence of an anesthesiologist, gynecologist and allergist. We tested ropivacaine because of its use for prolonged epidural analgesia and sub-arachnoid anesthesia for caesarean section. We believe that investigating LA allergies in pregnancy can offer multiple advantages in childbirth analgesia and caesarean section.

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The journey towards nomenclature standardization for interfascial plane blocks: there is still much to do

Interfascial plane blocks have been a prolific research field in the last few years, with several blocks being proposed in a short span of time. The introduction of these new blocks overwhelmed scientific journals with similar block procedures published under different names, with the net effect of creating confusion among physicians. In this framework, the ASRA/ESRA consensus¹ published in 2021 was an essential step to increase clarity and promote standardization in clinical practice and research. It is our opinion that recent literature is failing to catch up, with the excellent publication by Giacomino *et al.*² in 2022 exemplifying this aspect. In this article, the authors describe the use of PECS II, instead of using the new nomenclature. In fact, the novel nomenclature suggests using the term “interpectoral” and “pecto-serratus” to identify the blocks previously named as “PECS I” and “PECS II” respectively.³ This letter aims to evaluate the implementation of the new nomenclature using the pectoral nerve block case as an example. We performed a systematic research of the literature on March 9th, 2022, with one of the authors (ADC) retrieving all articles indexed on PubMed using the following search strategy: (Pectoral* or PECS or interpectoral or interpectoral or pecto-serratus or pectoserratus) AND block. We retrieved 889 results, however 820 results were excluded as they were published before the 18th of June 2021 (ASRA/ESRA consensus publication date). Of the remaining 69 articles, one was a retraction notice, one was a Spanish translation producing a duplicate record, eight articles regarded other regional anesthesia procedures and 31 were outside of the topic leaving a total of 28 articles included in our analysis. After reading the full text, we divided them into two groups depending on the use of the old or the new nomenclature (Figure 1). As depicted in Figure 1 the new nomenclature has

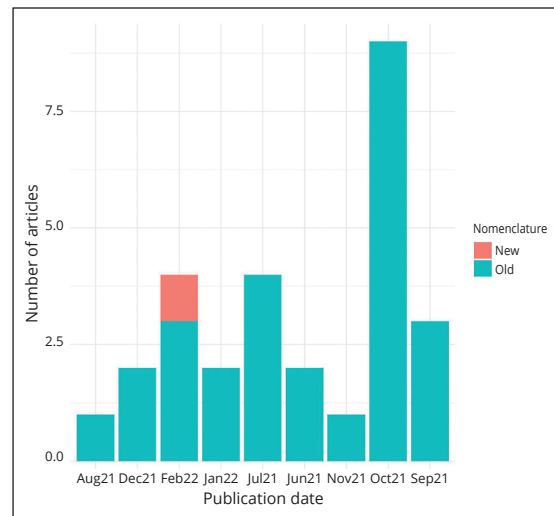


Figure 1.—Bar plot showing number of publications over time since the ASRA/ESRA consensus subgrouped by the use of the old or the new nomenclature.

actually been rarely used in current research. PECS I and II were the first interfascial plane blocks described in 2011 and 2012 by Blanco for postoperative analgesia in breast surgery.^{4,5} For this reason, they became iconic, and we believe that it will be difficult to fully eradicate their previous name from the cultural background of anesthesiologists. For this reason a particular effort of all editors, reviewers and authors of regional anesthesia research will be necessary to bridge the nomenclature gap. Our work has some limitations. First, the use of only one database may have led to missing potentially eligible papers. However, we believe that inclusion of missing papers would have not substantially modified our conclusions. Second, our research regarded only interpectoral and pectoserratus block and may not be generalizable to other fascial plane blocks. In conclusion, we believe that the direction traced by the ASRA/ESRA consensus is laudable, however, a collaborative effort would be necessary to implement the new nomenclature in the current clinical practice, with researchers and editors requested to be on the front line of this change.

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