Anaesthesia Q & A

This is the final instalment of our Anaesthesia Q+A with Dr Anton Krige, consultant anaesthetist.

Q. ***I take low dose naltrexone. What impact will this have on the pain relief I have post surgery.***

A. Naltrexone is a drug used to manage long term opiate/alcohol withdrawal. Its dose is 25 – 50mg. It was discovered in the 1990's that a fraction of that dose i.e. 0.1 – 4.5mg - thus called Low Dose Naltrexone of LDN - had an immune modulating effects and improved symptoms in a range of cancers, autoimmune conditions & ME/CFS in some patients (not all & it is usually trialled for 2 months to assess response & only continued if benefit is felt). As large scale studies have never been done & unlikely to funded by pharma as the drug is off patent it is not on the BNF & thus not available in the NHS. It is produced from the full dose naltrexone in compounding pharmacies & is therefore classed as an Unlicensed Medication. Most NHS doctors will not have heard of this medication.

For more information on low dose naltrexone see the LDN Research Trust.
https://ldnresearchtrust.org/

Q. ***If I were to have emergency surgery how would my pain be managed as I take low dose Naltrexone?***

A. It would depend on the nature of the emergency surgery but would require some form of regional analgesia i.e. one of many techniques blocking the nerve supply to the area being operated. Depending on the surgery this would often need to be combined with general anaesthesia but would be the key part of the pain relief as opiate drugs e.g. morphine would not be as effective with LDN in place. This would also be combined with multiple other non-opioid pain killers so the combination provided optimal pain relief - so-called multimodal analgesia.

Q. ***Is it the case, as has been suggested, that drugs such as Modafinil given in the operating theatre doesn't give more energy to people with ME.***

A. I have no knowledge or experience of this medication & have never encountered a patient on it. It would not be used in the NHS in anaesthesia & I see its BNF indication is to treat narcolepsy.

Q. ***I have very frequent daily medication, more than the typical four times day in the hospital. Is there any way I could be allowed to self-administer or get my relative to give me my medication*****.**

A. You would have to discuss this with your local hospital & a question to ask your surgeon & Pre-op Assessment Clinic staff.

Q. ***I've never heard of a hospital pain team. What do they do? Will they be at the pre-operative assessment clinic?***

A. The acute pain team are nurses that are very knowledgeable about all the pain relief techniques used following major surgery for in-patients & are supervised by a Consultant Anaesthetist with an interest in that area. The will create hospital wide guidelines for managing pain after the different types of major surgery & do ward rounds every day to review the patients who've had major surgery & assess the quality of their pain relief & make medication & suggestions. In some hospitals they've received training to be able to prescribe medication themselves. They will usually be a day time Monday to Friday service & leave plans for the weekend with the on call anaesthesia team trouble shooting pain relief issues on surgical wards out of hours. All doctors in the different ward areas are able to manage pain relief but the Acute Pain Team are more expert & experienced.

They won't be in the Pre-Op Clinic but if the deemed to be complex pain relief patient i.e. chronic pain & chronic pain meds then they may be alerted & informed about the planned case ahead of time.

I have been seen by the hospital pain clinic. They offered me intravenous lidocaine. Have you had experience of using this with people with ME?

Lidocaine is a common short acting local anaesthetic (LA) medication used to infiltrate skin or other tissue & numb the area to perform minor surgery. It's the LA usually used by dentists. It has also been found to be useful when give as a short duration infusion intravenously for certain types of chronic pain which would be administered by a Chronic Pain specialist in a monitored setting in hospital. Chronic Pain specialist are Consultants in Anaesthesia who have trained in Chronic Pain management as a sub specialty

It is not used to treat ME & so the indication would be a form of chronic pain where it has some evidence of effectiveness & not the ME itself. I cannot comment on individual cases & treatments, so this is purely general information about the modality.

Q. ***Are most anaesthetists familiar with POTS? Cardiologists who see people with POTS are thin on the ground in London. Is this the case across the country?***

A. No, I don't think many will be familiar.

Yes, there are few cardiologists with an interest nationally.

Q. ***I have skin reactions to many surgical tapes, dressings and Elastoplast.***

I'm OK with Mefix and Mepore. Who should I report this to? Will the hospital have alternatives or should I purchase my own and take them in with me?

A. This is common with many patients not just ME patients. Inform the anaesthetist on the day & the anaesthetic nurse that will check you in & they'll make adjustments. All allergies are discussed at Team Brief before the list starts.

Q. ***What training is required to qualify as an anaesthetist? How long does it take to train to be an anaesthetist?***

A. Once doctors graduate from 5 years of medical school they ball do 2 years as Foundation Doctors rotating through all specialties & are closely supervised. Those wishing to specialize may need to spend another few years working as a resident doctor in that specialty in order to gain a competitive specialty training position. In anaesthesia they would then be a specialty training (ST) doctor for 7 years before completing training & becoming eligible to apply for a post as a Consultant in Anaesthesia. The training curriculum is set by the Royal College of Anaesthetists & along the way they will sit to sets of rigorous examinations of theoretical & practical knowledge to gain the degree of FRCA – Fellow of the Royal College of Anaesthesia. Those that are dual accredited in Critical Care will do an 8th training year as an advanced ICU trainee & do an extra degree examination for FFICM. Oher sub-specialities also require extra fellowships e.g. Paediatric, Neuro, Cardiothoracic, Chronic Pain Anaesthetics. Most are mid 3o's before becoming a Consultant in Anaesthesia with a massive amount of knowledge, experience & skills.

Q. ***What roles do anaesthetists take on beyond working in operating theatres?***

A. Critical Care

Acute Pain Rounds

Chronic Pain Clinics

Pre-op assessment clinic session & Cardiopulmonary Pre-op Clinic sessions

Sub-specialty areas: obstetric anaesthesia, cardiothoracic, neuro, paediatric, military etc

Perioperative physicians

Critical Care Consultants

Academia & research

Q. ***How did your working day change during the pandemic?***

A. Did pure critical care & no anaesthesia with altered working patterns due to the intensity - shortened shifts of 8 hrs but much higher frequency (all non-clinical roles were stopped & clinical component hugely increased) and on calls as resident in the hospital through the night with the resident doctors (junior doctors) to directly support them rather than on call from home at night as is usual practice for consultants

Q. ***As an anaesthetist would you welcome training opportunities for colleagues about ME? What do you think this should look like?***

A. Simply include it as medical comorbidities to learn about regarding how anaesthesia would be modified just as for all other comorbidities e.g. diabetes, cardiovascular disease, respiratory disease etc

The challenge is that no peer reviewed published data regarding anaesthesia & ME exist that would meet academic standards other disease areas.

A proposal for an educational article on ME & Anaesthesia has been accepted by the British Journal of Anaesthesia Education journal which reaches all UK anaesthetists & will be a good start – this will depend on it passing peer review once written & will be submitted in 2025

Q. ***What training is needed to achieve better outcomes for people with ME having surgery?***

A. Not training - it's not procedural skills - just more knowledge & awareness of patient specific issues. Anaesthetists already have the skill sets once they understand the issues & simple practical adjustments to make..

We would like to say a huge thank you to Dr Krige for answering all of our questions. We have never had so many questions!

All previous Q+A's are available from the 25% ME Group website under resources. See **https://25megroup.org/resources/group-newsletter-qa/**

Our next Q+A will be with Vikki Weller, a nurse co-ordinator with NHS Continuing Healthcare. Vikki is a Registered Nurse and began her career in the NHS working in hospitals and community rehabilitation units, moving on to managing Nursing/ Care homes. Vikki has worked for the NHS Continuing Healthcare Team for over 7 years now. The role is varied and consists of assessing people for continuing healthcare funding and being a case manager for people who have care and support packages funded by the NHS to meet their assessed level of needs.

Please send in questions you have about NHS Continuing Healthcare to Helen Baxter no later than 30th September. Her email address is ***hbaxter@25megroup.org***