Does Continuous Peripheral Nerve Block Provide Superior Pain Control to Opioids? A Meta-Analysis

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Although most randomized clinical trials conclude that the addition of continuous peripheral nerve blockade (CPNB) decreases postoperative pain and opioid-related side effects when compared with opioids, studies have included relatively small numbers of patients and the majority failed to show statistical significance during all time periods for reduced pain or side effects. We identified studies primarily by searching Ovid Medline (1950–May 21, 2006) for terms related to postoperative analgesia with CPNB and opioids. Each article from the final search was reviewed and data were extracted from tables, text, or extrapolated from figures as needed. Nineteen articles, enrolling 603 patients, met all inclusion criteria. Inclusion criteria were a clearly defined anesthesia technique (combined general/regional anesthesia, general anesthesia alone, peripheral nerve block), randomized trial, adult patient population (≥18 yr old), CPNB (or analgesia) used postoperatively (intrathecal catheters were deemed not to be classified as a peripheral nerve catheter), and opioids administered for postoperative analgesia in groups not receiving peripheral nerve block. Perineural analgesia provided better postoperative analgesia compared with opioids (P < 0.001). This effect was seen for all time periods measured for both mean visual analog scale and maximum visual analog scale at 24 h (P < 0.001), 48 h (P < 0.001), and 72 h (mean visual analog scale only) (P < 0.001) postoperatively. Perineural catheters provided superior analgesia to opioids for all catheter locations and time periods (P < 0.05). Nausea/vomiting, sedation, and pruritus all occurred more commonly with opioid analgesia (P < 0.001). A reduction in opioid use was noted with perineural analgesia (P < 0.001). CPNB analgesia, regardless of catheter location, provided superior postoperative analgesia and fewer opioid-related side effects when compared with opioid analgesia.

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Single injection peripheral nerve blocks are effective for postoperative pain after both upper and lower extremity surgery but are limited by the duration of action of local anesthetics. Continuous peripheral nerve blockade (CPNB) provides the potential benefits of single injection techniques (e.g., decreased pain, respiratory depression, and nausea/vomiting) well into the postoperative period (1,2). Furthermore, the introduction of mechanical and electronic pumps for the continuous infusion of local anesthetic has allowed patients to receive the benefits of continuous catheters after leaving the hospital (4–7).

Numerous clinical trials have been published examining the efficacy of CPNB for the treatment of postoperative pain after both upper and lower extremity surgery compared with systemic opioids. Although most randomized clinical trials conclude that CPNB decreases postoperative pain and opioid-related side effects when compared with opioids, studies have included a relatively small number of patients and the majority failed to show statistical significance during all time periods for reduced pain or side effects. The objectives of this meta-analysis were to evaluate data from randomized clinical trials (RCTs) to determine 1) efficacy of perineural catheters for reducing postoperative pain, 2)
Table 1. Categories of Data Analyzed from Each Study

Methodology
- Blinding: yes, no
- Region of surgery: thoracic, pelvic, abdominal, lower extremity, upper extremity

Peripheral Nerve Catheter Data
- Catheter Location: axillary brachial plexus, interscalene brachial plexus, infracavicular brachial plexus, other
  - brachial plexus, sciotic, femoral, popliteal, paravertebral

Opioid Data
- Type: intravenous, intramuscular, oral, other

Supplemental Analytic Data
- Type: NSAIDs, COX-2, propacetamal, other, combination
- VAS Pain Scores (Converted to 0−10 Scale)
  - Type: mean VAS, maximum VAS

Dosage Use and Technique
- Dose: average daily consumption of intravenous and oral opioid given

Major Complications
- Death
- Stroke
- Cardiovascular complications: hypotension, myocardial infarction, myocardial ischemia, arrhythmia
- Pulmonary complications: respiratory depression, incidence of desaturation events, pneumonia, other
- Renal complications, deep venous thrombosis, pulmonary embolism, transfusion reaction, wound infection, sepsis, other

Minor Complications
- Nausea or vomiting
- Confusion or delirium
- Sedation
- Pruritus
- Constipation
- Urinary retention
- Headache
- Backache
- Motor block/weakness
- Patient satisfaction

NSAIDs = nonsteroidal anti-inflammatory drugs; COX-2 = cyclooxygenase-2 inhibitor; VAS = visual analog scale.

Methods
A search of Ovid Medline to identify RCTs comparing CPNB with opioids for the management of postoperative pain from 1966 to the third week of May 2004 with the terms “Pain, postoperative” (13,752 articles) combined with “nerve block” (7399 articles) yielded 788 articles. Limiting this to RCTs, human and all adults (≥19 yr) yielded 236 articles. We reviewed each of the abstracts of these articles to determine if there was a description of the use of continuous peripheral nerve catheters for postoperative pain in one of the randomized groups and opioids (either oral or parenteral) in the other randomized group. This search identified 37 articles for further review of the full article to determine if inclusion criteria were met. A review of the author’s files and references from the original search yielded an additional 7 articles for review. Inclusion criteria were a clearly defined anesthetic technique (combined general/regional anesthetia, general anesthesia [GA] alone, peripheral nerve block), randomized trial, adult patient population (≥18 yr old), CPNB (or analgesia) used postoperatively (intraveous catheters were deemed not to be classified as a peripheral nerve catheter), and opioids administered for postoperative analgesia in groups not receiving peripheral nerve block. Exclusion criteria were no measurement of pain score that could be converted to visual analog scale (VAS) or no comparison of opioid to CPNB. Each article was reviewed by two separate authors with a third author used to resolve any disputes on the inclusion of any articles.

The analyzed items are reported in Table 1. Methodology and results were recorded for each study. Incidence rates for complications were recorded for each study as reported, using the larger number for nausea and vomiting if both were recorded. Although opioids were used in both treatment groups, a classification of opioid or CPNB was made to more easily indicate the two separate groups for the purpose of data analysis.

All recorded data were separated into individual subgroups as described in Table 1. Each VAS pain score was converted based on a 0 to 10 scale (all data measured using a 0−100 VAS scale were converted to a 0 to 10 scale). The standard error of each mean, if not
given, was computed using the given standard deviation and sample size. If a median and interquartile range were reported, these were converted to a mean and standard deviation based on the assumption of a lognormal distribution of the original measure.

Overall, pooled means for each of the measures were computed by taking a sample size-weighted average of the reported (or estimated) means from each study as follows:

\[
\bar{X}_{\text{pooled}} = \frac{\sum_{i=1}^{N} (n_i \times \bar{X}_i)}{\sum_{i=1}^{N} n_i}
\]

where \(i\) indexes a specific study, \(\bar{X}_i\) is the study-specific mean, and \(n_i\) the study specific sample size. The standard error (se) of each overall mean was computed by the following formula:

\[
se(\bar{X}_{\text{pooled}}) = \sqrt{\frac{\sum_{i=1}^{N} (n_i^2 \times se^2(\bar{X}_i))}{\left(\sum_{i=1}^{N} n_i\right)^2}}
\]

where \(se(\bar{X}_i)\) is the study specific standard error of the mean. Articles that included data for multiple time points were included in the analysis. For VAS pain scores measured on postoperative days 1 through 3, time values of 24 h, 48 h, and 72 h were respectively assigned to account for differences in data observation among included studies. Opioid consumption other than IV morphine (e.g., oral, IM, or non-morphine IV opioid) was converted to IV morphine equivalents.

Data were extrapolated from graphs as needed using averaged manual measurements by two of the authors. VAS data were weighted by sample size, with the number reported for each article being the number of subjects in each treatment group. The VAS scores for each time period and complication rates were compared between treatment groups. Peripheral nerve catheter analgesia may not provide equivalent analgesia for all catheter locations; therefore, we subdivided the data by catheter location and compared perineural catheters to opioid analgesia. All peripheral catheter local anesthetic infusions were considered equivalent, including those with and without additives (e.g., clonidine). Similarly, all opioids were considered equivalent. Both rest and maximal pain were included in the analysis and were further subdivided based on catheter location.

Complications and side effects reported in the studies were recorded and analyzed, although not every article reported all possible complications. A complication rate of 0% was not assumed if studies failed to report a particular complication.

The level of significance for all tests was set at an \(\alpha\) level of 0.05 and variances were not assumed to be equal. A Kolmogorov test showed that the data were normally distributed. One-way analysis of variance tests, weighted by sample size, were used to compare VAS pain scores. A \(\chi^2\) analysis was used to analyze complication data between treatment groups. The resulting odds ratio was used to compute number needed to treat (NNT) for complication data. All statistical analyses performed used SPSS 11.5.1. (SPSS Inc., Chicago, IL).

Cost data for local anesthetic infusion pumps were pulled from that reported by Ilfeld et al. (8) for C-Bloc (I-Flow Corporation) $250, AutoMed 3200 (AceeMedical/Algos) $200, and Accufuser Plus (McKinley Medical) $260 disposable pumps. The cost for peripheral nerve catheter sets (Arrow International) quoted from a company representative was $60. Daily costs of morphine and bupivacaine are negligible and accurate data could not be located in the literature to compare with our institutional costs. Cost data for prevention of nausea and vomiting were pooled from recent publications examining a variety of antiemetic strategies (dexamethasone, dolasetron, droperidol, and ondansetron) in Europe and North America (9–12). The average incremental cost for one additional nausea-free and vomiting-free patient was $40.49 (United States dollars). Cost data for the treatment of pruritus were not found in the literature, although the costs of naloxone and diphenhydramine (two of the commonly used drugs for the treatment of pruritus) are minimal. Cost data for sedation are not available. The actual cost associated with catheter placement was not found in the literature.

At the completion of the data collection and analyses, additional analyses were done to assess the validity of the conclusions that were drawn. An analysis of the file drawer problem was performed to calculate how many studies that displayed no difference between treatment groups would be needed to invalidate our results.

A funnel plot was also created to indicate any publication bias or other biases in our meta-analysis (English language, citation, and multiple publications) (13). The natural logarithm of relative VAS scores versus precision of the studies was used to create the funnel plot. Relative VAS was calculated by dividing the mean VAS score at 24 h for patients who received a peripheral nerve catheter by the mean VAS score at 24 h for patients who received an opioid for each trial. A relative VAS of <1 signifies better analgesia with peripheral nerve catheter techniques. The precision of studies was calculated by using the inverse of the standard deviation of the mean difference between the same VAS scores.
Table 2. Characteristics of Included Studies

| Surgical site | Lower extremity | 12 [360] (60%) | Upper extremity | 7 [243] (40%) |
| Location of catheter | Femoral/lumbar plexus | 10 [310] (53%) | Interscalene | 6 [213] (35%) |
| | Other | 0 | Infracavicular | 1 [30] (5%) |
| | Pudendal | 2 [50] (8%) |
| Gender | Male | 2 [35] (59%) | Female | 2 [36] (43%) |
| | Undefined | 1 [10] (18%) |
| Location | Europe | 11 (58%) | USA | 5 (27%) |
| | Canada | 2 (11%) | Asia | 1 (5%) |

Numbers in brackets represent total number of subjects in trials; numbers outside brackets represent number of trials. A total of 19 studies met inclusion criteria. Three trials totaling 110 patients did not document the breakdown of male/female patients, but did state that no significant differences occurred between the two sexes. Because of rounding, the sum of values expressed in % may not equal 100%.

Results

A total of 19 articles, enrolling 603 patients, were ultimately included in the meta-analysis (Appendix). The characteristics of included studies, which also contain additional data (demographics and study location) recorded but not necessarily quantified for analysis, are shown in Table 2. Included articles came primarily from hospitals in Europe (58%) and North America (38%). More studies involved lower extremity surgery (60%) than upper extremity (40%) with femoral nerve/lumbar plexus the most common catheter location for analgesia (51%) followed by interscalene (35%). Randomized clinical trials comparing perineural catheters with opioids were very limited for other locations (13%). Individual study results were summarized according to upper extremity (Table 3) and lower extremity (Table 4).

Studies in the analysis included 11 with data obtained by intention-to-treat (all enrolled patients were included in the data analysis with no treatment failures), whereas only adequately functioning catheters were included in the remaining 8 studies. A total of 13 patients were withdrawn from the catheter group after randomization and 7 excluded from the opioid group in these 8 studies. Ten additional patients were withdrawn before randomization. Overall, there were 10 catheter placement failures, 11 catheter dislodgements, and 2 patients in the catheter groups excluded for other reasons, whereas 5 patients in the opioid group were withdrawn because of nausea and 2 for failure to complete surveys.

When all studies and observations were combined, perineural analgesia provided better postoperative analgesia compared with opioids (P < 0.001). This effect was seen for all time periods measured for both mean VAS (Fig. 1) and maximum VAS (Fig. 2) at 24 h (P < 0.001), 48 h (P < 0.001), and 72 h (mean VAS only) (P < 0.001) postoperatively. When analyzing by catheter location, perineural analgesia provided superior analgesia to opioids (P < 0.05) for all locations and time periods (Table 5). The funnel plot demonstrated a relative VAS of less than one for all trials, indicating better analgesia with the CPNB technique. Analysis of the file drawer problem indicates 168 subjects who displayed no difference between treatment groups would be needed to invalidate our results. This indicates that this meta-analysis is not very resistant to the file drawer problem, which is likely attributed to the small overall number of studies with small numbers of study subjects in each.

There were no major complications reported in any of the 19 studies. Twelve of the 19 studies (63%) reported at least one minor complication, with sedation occurring most frequently overall. Motor block was the adverse effect most attributable to peripheral nerve block (P < 0.001) whereas nausea/vomiting, sedation, and pruritus all occurred more commonly with opioid analgesia (P < 0.001) (Table 6). The NNT was calculated for nausea/vomiting, sedation, and pruritus with 4, 4, and 6 patients receiving perineural analgesia expected to result in one less patient with nausea/vomiting, sedation, and pruritus, respectively, compared with opioid analgesia (Table 6).

Four trials measured patient satisfaction on a VAS and demonstrated a higher composite mean VAS satisfaction for catheters 9.6 (n = 95) (95% confidence interval [CI], 9.5–9.7) compared with opioids 7.1 (n = 90) (95% CI, 6.9–7.2). Total opioid consumption for both groups for the duration of catheter use was calculated for 12 of 19 studies. Seven studies either failed to document total opioid consumption for both groups or did not provide the data in a manner that could be converted for direct comparison. Total opioid consumption over 48 h was significantly less (P < 0.001) with the use of perineural analgesia (20.8 mg morphine, n = 165 patients [95% CI 18.5–23.1]) compared with opioid analgesia (54.1 mg morphine, n = 174 patients [95% CI, 50.8–57.4]). A limited cost analysis demonstrated an average cost of the catheter kit and disposable infusion pumps to total $296.67 (US dollars). Based on a NNT of 4, the use of CPNB analgesia would result in an average savings of $10.12 (US dollars) per patient for the treatment of nausea/vomiting.

Discussion

CPNB has been proposed to offer similar benefits to single injection techniques extending well into the
Table 3. Included Prospective Randomized Controlled Trials Comparing Upper Extremity Continuous Peripheral Nerve Block to Opioid Analgesia

<table>
<thead>
<tr>
<th>Study</th>
<th>Type of Surgery</th>
<th>Catheter location</th>
<th>N</th>
<th>Infusion in catheter</th>
<th>Opioid used</th>
<th>Both groups received single shot bolus?</th>
<th>Was patient-controlled analgesia used?</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berge et al. 1998</td>
<td>Major shoulder surgery</td>
<td>Intercutaneous</td>
<td>30 C</td>
<td>0.2% ropivacaine*</td>
<td>Nicomorphine IV PCA (O)</td>
<td>Y</td>
<td>N</td>
<td>SS higher patient satisfaction, decrease in nausea, pruritus, and mean VAS at 12 and 24 h with CPNB</td>
</tr>
<tr>
<td>Berge et al. 1997</td>
<td>Major shoulder surgery</td>
<td>Intercutaneous</td>
<td>20 C</td>
<td>0.15% bupivacaine*</td>
<td>Nicomorphine IV PCA (O)</td>
<td>Y</td>
<td>N</td>
<td>SS decrease in vomiting and pruritus and SS decrease mean VAS pain at 12 and 24 h only with CPNB</td>
</tr>
<tr>
<td>Berge et al. 2000</td>
<td>Major shoulder surgery</td>
<td>Intercutaneous</td>
<td>18 C</td>
<td>0.2% ropivacaine*</td>
<td>Nicomorphine IV PCA (O)</td>
<td>Y</td>
<td>N</td>
<td>SS higher patient satisfaction, decreased nausea/vomiting and median VAS pain at 12 and 24 h with CPNB, No SS change in diaphragm excursion</td>
</tr>
<tr>
<td>Kleis et al. 2000</td>
<td>Open rotator cuff repair</td>
<td>Intercutaneous</td>
<td>22 C</td>
<td>0.2% ropivacaine+</td>
<td>Morphine IV PCA (O) (C)</td>
<td>Y</td>
<td>Y</td>
<td>SS decrease mean VAS pain 12–24 h, reduction in morphine consumption with CPNB</td>
</tr>
<tr>
<td>lfi et al. 2003</td>
<td>Outpatient shoulder surgery</td>
<td>Intercutaneous</td>
<td>10 C</td>
<td>0.2% ropivacaine*</td>
<td>Oxycodone IV PCA (O) (C)</td>
<td>Y</td>
<td>Y</td>
<td>SS decrease in nausea, sedation, pruritus, opioid consumption and average and max. VAS pain at 12 and 24 h with CPNB, No difference in side effects or opioid consumption</td>
</tr>
<tr>
<td>Lohle et al. 1999</td>
<td>Acromioplasty</td>
<td>Intercutaneous</td>
<td>10 C</td>
<td>0.25% bupivacaine+</td>
<td>Morphine IV PCA (O)</td>
<td>N</td>
<td>N</td>
<td>SS decrease in mean VAS pain at 12 and 24 h with CPNB, No difference in side effects or opioid consumption</td>
</tr>
<tr>
<td>lfi et al. 2002</td>
<td>Outpatient upper extremity surgery at ar or below elbow</td>
<td>Intercutaneous</td>
<td>15 C</td>
<td>0.2% ropivacaine*</td>
<td>Oxycodone IV PCA (O)</td>
<td>Y</td>
<td>Y</td>
<td>SS decrease in nausea, sedation, difficulty sleeping (24 h) and SS decrease average and max. VAS pain and opioid consumption (24 and 48 h) with CPNB</td>
</tr>
</tbody>
</table>

C = catheter group; O = opioid group; PCA = patient-controlled analgesia; SS = statistically significant; VAS = visual analog scale score; CPNB = continuous peripheral nerve block.

* Continuous infusion with bolus available; +Continuous infusion without bolus; #Third group with IA/IV morphine not included in analysis.

Postoperative period in both the ambulatory and inpatient settings. We performed a meta-analysis of RCTs and found that, when compared with opioid (parenteral and oral), perineural analgesia with local anesthetic provided significantly better analgesia for postoperative pain. Improvements in analgesia were noted through postoperative day 3. When analyzed according to catheter location, (e.g., interscalene, femoral, popliteal) and type of pain assessment (rest versus maximal pain), CPNB provided superior postoperative analgesia compared with opioids. Perineural analgesia also resulted in fewer minor complications, including nausea/vomiting, pruritus, and sedation, and improved patient satisfaction.

Single injection peripheral nerve blocks have been demonstrated to provide superior pain control and decreased side effects compared with the use of opioids (14,15). These techniques are limited by the relatively short (12–24 hours) duration of analgesia provided by a single injection nerve block. Although epidural patient-controlled analgesia (PCA) and IV PCA provide adequate analgesia for inpatients with postoperative pain, these techniques are unsuitable for postoperative pain management after...
Table 4. Included Prospective Randomized Controlled Trials Comparing Lower Extremity Continuous Peripheral Nerve Block to Opioid Analgesia

<table>
<thead>
<tr>
<th>Study</th>
<th>Type of surgery</th>
<th>Catheter location</th>
<th>N</th>
<th>Infusion in catheter</th>
<th>Opioid used</th>
<th>Both groups received single shot blocks?</th>
<th>Placebo catheter used?</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hirut et al. 1996</td>
<td>Total knee arthroplasty</td>
<td>Femoral 3-in-1</td>
<td>31</td>
<td>0.125% bupivacaine###</td>
<td>Morphine IV PCA (C)</td>
<td>Y</td>
<td>Y</td>
<td>SS reduction in nausea with CPNB. No SS decrease in VAS pain or opioid consumption.</td>
</tr>
<tr>
<td>Ganzopt et al. 1997</td>
<td>Total knee arthroplasty</td>
<td>Femoral 3-in-1</td>
<td>22</td>
<td>0.2% bupivacaine###</td>
<td>Morphine IV PCA (C)</td>
<td>N</td>
<td>Y</td>
<td>No SS decrease in VAS pain or opioid consumption.</td>
</tr>
<tr>
<td>Serpell et al. 1999</td>
<td>Total knee replacement</td>
<td>Femoral 3-in-1</td>
<td>15</td>
<td>0.5% bupivacaine###</td>
<td>Morphine IV PCA, Morphin IM PRN (C)</td>
<td>N</td>
<td>N</td>
<td>SS decrease in morphine use with catheter. SS decrease in VAS pain, nausea, or vomiting.</td>
</tr>
<tr>
<td>Griffith et al. 1996</td>
<td>Femoral-popliteal Femoral bypass</td>
<td>Femoral 3-in-1</td>
<td>10</td>
<td>0.5% bupivacaine###</td>
<td>Morphine IV PCA Dilatrocurine RO:54 b (C) (C)</td>
<td>N</td>
<td>N</td>
<td>SS decrease in VAS pain and opioid requirements at 24, 48 and 72 h within CPNB.</td>
</tr>
<tr>
<td>Coignet et al. 2004</td>
<td>Skin graft on burn patients</td>
<td>Femoral</td>
<td>10</td>
<td>0.2% ropivacaine###</td>
<td>Morphine IV PCA (C)</td>
<td>N</td>
<td>N</td>
<td>SS decrease in opioid requirements and VAS pain at donor site (64 and 96 h) with CPNB. No SS difference in nausea/vomiting or pruritus.</td>
</tr>
<tr>
<td>Edwards et al. 1999</td>
<td>Total knee replacement</td>
<td>Femoral 3-in-1</td>
<td>19</td>
<td>0.125% bupivacaine###</td>
<td>Propacetamol IM (C) (C)</td>
<td>N</td>
<td>N</td>
<td>SS decrease in VAS pain at 24 h and opioid requirements with CPNB.</td>
</tr>
<tr>
<td>Stoodley et al. 1998</td>
<td>Total knee arthroplasty</td>
<td>Femoral 3-in-1</td>
<td>15</td>
<td>0.12% bupivacaine</td>
<td>Morphine IV PCA IM Fentanyl (C)</td>
<td>N</td>
<td>N</td>
<td>SS decrease in VAS pain (3rd and 48 h) and max (24 h) and improvement in knee flexion (up to 5°) with CPNB. No SS difference in nausea.</td>
</tr>
<tr>
<td>Chadfom et al. 1999</td>
<td>Hip fractures</td>
<td>Femoral 3-compartment 3-in-1</td>
<td>20</td>
<td>0.25% bupivacaine###</td>
<td>Mepivacaine IM</td>
<td>N</td>
<td>N</td>
<td>SS decrease in VAS pain (24, 48, and 72 h) and higher satisfaction with CPNB.</td>
</tr>
<tr>
<td>Capdevilla et al. 1999</td>
<td>Major knee surgery</td>
<td>Femoral</td>
<td>19</td>
<td>1% Lidocainе 2 µg/ml + sugammadex 0.03 µg/ml morphine###</td>
<td>Morphine IV PCA (C)</td>
<td>N</td>
<td>N</td>
<td>SS decrease VAS pain (24 and 48 h), improved knee flexion (day 5 and discharge) with CPNB.</td>
</tr>
<tr>
<td>Sreberzb et al. 1996</td>
<td>Femoral neck fracture</td>
<td>Femoral 3-in-1</td>
<td>12</td>
<td>0.5% bupivacaine###</td>
<td>Morphine IV/IM</td>
<td>N</td>
<td>N</td>
<td>No SS difference VAS pain or side effects. SS decrease VAS max. and average VAS pain (24, 48 h), decreased salivation, opioid ingestion, sedation, nausea, pruritus, insomnia (24 and 48 h) with CPNB.</td>
</tr>
<tr>
<td>Lesh et al. 2002</td>
<td>Ambulatory orthopedic surgery below knee</td>
<td>Sciatic popliteal fossa</td>
<td>10</td>
<td>0.2% ropivacaine###</td>
<td>Gocyclone PO (C) (C)</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White et al. 2003</td>
<td>Ambulatory orthopedic surgery below knee</td>
<td>Sciatic popliteal fossa</td>
<td>10</td>
<td>0.25% bupivacaine###</td>
<td>Morphine IV PCA IV FBN and hydrocortone PO (C) (C)</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Continuous infusion used with no bolus; # bupivacaine administered in intermittent bolus by physician as needed but did not have continuous infusion; ** Continuous infusion used with bolus available; N = number of patients in each group; C = catheter group; O = opioid group; IV = intravenous; SS = statistically significant; VAS = visual analog scale; CPNB = continuous peripheral nerve block; PCA = patient-controlled analgesia; IM = intramuscular; SC = subcutaneous.
outpatient surgical procedures. More than 40% of patients undergoing ambulatory orthopedic procedures experience moderate to severe pain postoperatively (16). There are several reasons that perineural catheters may provide better postoperative analgesia compared with parenteral opioids, including the fact that local anesthetics may attenuate or block painful input into the central nervous system.

The overall incidence of side effects was similar to that noted in reviews of opioid analgesia and single injection peripheral nerve blocks. An expected incidence of 15% for pruritus (17) and 50% for nausea/vomiting (18) are similar to results obtained for our opioid group. The use of CPNB resulted in less side effects (nausea/vomiting, sedation, and pruritus) than opioid analgesia. CPNB do not generally obviate the need for opioids entirely. The description of opioid use varied significantly in the RCTs, making it difficult to analyze data on reduced opioid consumption; however, a statistically significant decrease in opioid requirements was noted overall with use of CPNB. The use of opioids in this group may contribute to the sedation, pruritus, and possibly nausea/vomiting that were noted in patients with CPNB analgesia. The group receiving CPNB reported more frequent motor block, although the incidence (31.4%) was less than would be expected for single injection blocks, likely as a result of decreased concentration and smaller volumes of local anesthetic associated with continuous infusions.

Individual RCTs suggest additional benefits including improved patient satisfaction (6,19), better sleep patterns (6,7), improved rehabilitation (1,20), and shorter hospital stays (1,19). Improved patient satisfaction in our study was statistically significant; however, data came from only 4 studies. Further studies to confirm these benefits, in addition to the advantage of decreased pain and decreased opioid-related side effects, may be incorporated into a cost-benefit analysis.

There are several limitations to this study, including those that relate to the general use of a meta-analysis and others which are specific to the issue examined (opioid versus perineural catheter analgesia). The clinical significance of our findings with regard to decreases in mean and maximal VAS may not correlate with the finding of a statistically significant decrease in pain with the use of perineural catheters. Although an approximate 50% reduction in VAS scores was noted at all time periods, a decrease of 2 cm (on a 0–10 cm scale) may not be clinically meaningful (e.g., a 50% reduction from a VAS of 0.5 to 0.25 is likely to be clinically insignificant whereas a decrease in VAS from 10 to 5 is likely to have a large clinical impact). Reductions in VAS scores of the magnitude observed in our study are consistent with values that have been suggested to be a clinically relevant reduction in pain scores (21,22).

Although the data were weighted by trial size, they were not weighted by the quality of the RCTs used nor were they assessed in a blinded fashion. The effects of assessing quality of the RCTs or assessment in a blinded fashion of the estimate of intervention efficacy reported in a meta-analysis are unclear (23). This may play a significant role in the analysis, as several of the trials were of poor quality. Only 11 of the 19 studies were double-blind with catheters placed in both groups. One study did not involve continuous infusion or patient-controlled intermittent bolus of local anesthetic but rather a physician-controlled bolus every 6 hours (24). This study was among those that failed to show a benefit for the use of perineural catheters, and exclusion of
the results would only strengthen the overall conclusion that analgesia is improved with perineural catheters.

We limited our meta-analysis to English language articles. This may introduce publication bias if only positive findings are published primarily in English language journals (25). The effect of excluding non-English language trials on the results of a meta-analysis is equivocal; however, some data suggest that omission of trials published in non-English journals may have little effect on the summary treatment effects and may result in a more conservative estimate of treatment effect (26). Our funnel plot showed little publication bias or other biases because almost all data points were plotted around a relative VAS of <1.0.

In examining the included studies for methodology, there was no consistency in analgesic regimen for either the opioid or perineural nerve catheter group. The opioid group included a variety of opioids, routes of administration (oral, parenteral), and frequency of administration, whereas the catheter group included different local anesthetics (bupivacaine and ropivacaine), concentrations (ranging from 0.125% to 0.5%), infusion rates, boluses, and catheter locations. Both groups also commonly had supplemental analgesics administered, including various nonsteroidal antiinflammatory drugs. This variability in protocol could affect the results of the study, although a trend towards a benefit with perineural analgesia appears to occur regardless of the analgesic regimen. Further studies to determine the ideal local anesthetic, concentration, infusion rate, bolus dose, and additives for each catheter site and surgical location are still needed to determine the optimal use of CPNS.

In summary, we performed a meta-analysis of RCTs to determine the analgesic efficacy of postoperative perineural catheter analgesia compared with opioid. Peripheral nerve catheter analgesia provided a statistically and clinically significant improvement in postoperative pain control compared with opioids and a decrease in opioid-related side effects. This effect was
seen at all time periods studied after surgery, for mean and maximal pain, and with all catheter locations.

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Appendix: Articles Meeting Inclusion Criteria


References


3. Deated in proof.
