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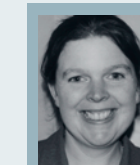
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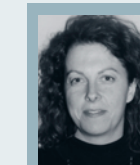
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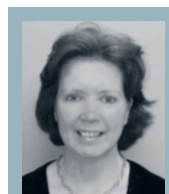
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Editorial

Conference Thoughts



Grainne McPolin

Editor

The Oxford English Dictionary defines the word 'Conference' as a 'formal meeting of people with a shared interest'. This definition however does not do justice to the meaning of the word when it is placed in context of the extensive planning and organisation necessary to undertake such an event.

Motivation, determination, initiative, patience and efficiency, are just some qualities that would describe those people behind the scenes who are prepared to spend many extra voluntary hours required to organise a conference in order to bring people together with a shared interest.

It can take up to twelve months of planning to bring people together from the specific disciplines of anaesthesia, recovery, midwifery and critical care. Delegates travel to the conference from many parts of the country to receive information on various topics pertinent to their practice. They become acquainted with new trends in the management and care of the patient needing anaesthesia and recovery. The conference setting is, in essence, a forum for the delegate to participate in on-going learning through the day by competing in a poster competition, posing questions to speakers, encouraging discussion between new acquaintances on skills and practice, enjoying time with colleagues and friends, organising re unions with old friends, meeting with trade exhibitors, winning prizes and gaining a unique insight into the cultural attractions of the city hosting the event.

One of the primary objectives of our chairperson, Sheila Murphy was to bring the conference to different locations in Ireland each year so that people would get the opportunity to network, learn and bring new ideas back to their units and departments.

A standard plan is adhered to by each committee that is convened especially to organise the event. The success of the conference becomes evident in the artistic creativity that shines through each person in the organising committee that have worked tirelessly to bring a large number of people together for the purpose of education, learning and professional development.

Grainne McPolin, Editor
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About the Journal

Irish Journal of Anaesthetic & Recovery Nursing

JOURNAL DESCRIPTION

The Journal is published on a quarterly basis and provides articles, reviews, letters and discussion on key topics, which are pertinent to the perianaesthesia nurse. Topics include updates on clinical issues, perianaesthesia nursing care, research on perianaesthesia nursing care, legislation and the practice of the perianaesthesia nurse. Other features include updates on practical innovations, book reviews, conference reports and education supplements.

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The Irish Journal of Anaesthetic & Recovery Nursing welcomes manuscripts pertaining to nursing practice in the areas of Anaesthesia and Recovery. The Journal endeavours to publish information on current trends in the provision of optimum health care. Manuscripts (which examine an area of clinical practice, details the author's research or discusses practical innovations), short-case studies, papers expressing professional opinions or letters are welcome from all members of the multidisciplinary team.

EDITORIAL AND PEER REVIEW POLICY

Manuscripts are evaluated by the Sub-Editor and two members of the IJARN Editorial Board while the Editor may modify the style of a contribution, major changes will be reviewed by the author prior to publication.

MANUSCRIPT PREPARATION

Submit three copies of the manuscript (on paper) and one copy on a disc (Microsoft Word document). Discs and paper copies of the manuscript will not be returned to the author. The manuscript must be double spaced, wide margin (3.17 cm left and right margins and 2.54 for top and bottom) and should be typed on one side of the paper only. The word count should be up to 2000 words (consult Sub Editor for specific advice). The top sheet should display: paper title, author's names, professional and academic qualifications, positions and place of work and address to which all correspondence should be sent. Figures, legends, tables, pictures (submitted on a separate page) should be referred to in the text and their appropriate position referred to in the margin. The main text should be preceded by a short summary (100-200 words).

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Communication in Multi-Ethnic Ireland - Considerations for Perioperative Nurses

Ireland is a multi-ethnic society, so it is essential that nurses generally and perioperative nurses specifically can communicate effectively with all patients who require their care. Well-developed skills in communication can enhance quality of care. There is a need for nurses to increase their self-awareness with regard to their own behaviour and the cultural factors that influence it. Increased demand for cultural communication skills in nursing is apparent and has created stress and frustration for healthcare providers. Irish policy makers and health service providers recognise the need to increase awareness of anti-racism and intercultural communication among all healthcare workers.

Human beings are unique and have personal dignity, which has personal meaning. Dignity is to treat a person with respect (Haddock 1996), concepts integral to nursing, but our challenges, as nurses is to further determine respect and understanding for individuals of other cultures in a multiethnic society in order to deliver appropriate and respectful care to patient/clients (Erlen 1998). Demonstrating respect, according to Sully and Dallas (2005), relates to the degree of equality and respect shown to people irrespective of their origin, wealth or social standing. Respect for culture includes; understanding, knowledge, communication, tolerance, support and acceptance of individuals from other cultures. In order to promote the dignity of another, feelings need to be clarified and understood to ensure patient focused care is delivered, rather than

nurse centred care. Nurses, must first be self aware before they become culturally aware. Norms, values and beliefs vary widely across cultures demonstrating to nurses the importance of not taking for granted basic elements of care relating to minority ethnic groups. It is apparent that patients and registered nurses share similar problems and challenges; those of effective communication, lack of cultural knowledge and understanding (Hayes 1995, Murphy and Mcleod 1993, Gerrish et al 1996, Boyle 1999 and Cortis 2000).

Patients' perspective of multi-ethnic care
Culturally appropriate nursing according to Wilkins (1993) is challenging because all societies have more than one culture. Newman Giger and Davidhizar (2002) argue that each individual is culturally unique. Individuals have their own personal cultural beliefs and values, and Western medicine offers a view of health and illness that may prove inappropriate to the patients understanding of their health care needs. According to Gerrish et al (1996 pg 36) "the user's voice is an important and irreplaceable, source of expertise" and she argues that patients' own understanding of their health status must be addressed. Provision of appropriate health care is therefore the responsibility of the practitioner in collaboration with the client (Warda 2000). Hayes (1995), Gerrish et al (1996) and Cortis (2000) examine the challenging experiences and problems encountered by multiethnic patients/clients. Gerrish et al (1996), as part of a larger study, examined minority ethnic communities experiences of nursing and midwifery care.

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The individual communities involved were of Afro-Caribbean, Chinese, Gujarati, Irish, Jewish, Pakistani, Polish, Sikh and Somali origin. Some positive experiences were reported where caring professionals were viewed as sensitive, while on the other hand negative attitudes were associated with the lack of knowledge and understanding of ethnic diversity. Three main themes emerged from the qualitative data of this study: (1) language, (2) respect and recognition of difference and (3) recognising and meeting cultural needs of ethnic communities. The inability to share a common language proved to be a major barrier to understanding (Gerrish et al 1996), the description of symptoms or in comprehending the treatment being offered. The language barrier impacted negatively upon a Chinese patient, admitted with a suspected myocardial infraction. She reported excellent first day care then followed, on day two by "being ignored as she could not communicate with the nurses".

generally"

Another example: a Jewish mother expressed to a nurse that she wished her baby boy to be circumcised; the nurse called this a barbaric act for someone so small and passed other degrading comments, but the mother highlighted to the nurse that it is part of her religious beliefs. The final theme that emerged from the study (Gerrish et al 1996) was "recognising and meeting cultural needs of ethnic communities". Many aspects of certain cultural beliefs and practices may be difficult to identify and comprehend from an outsider's perspective. Some aspects of living are basic human needs, shared by all cultures e.g. food. Yet food is a basic need that has many customs and rituals surrounding it; according to Gerrish et al (1996) it is one of the "most frequent signs of ethnocentric thoughtlessness". Such thoughtlessness includes the "assumption that because someone looks Asian they will choose



If her family had not translated and filled in the menu, she felt she would not have eaten anything. Another Chinese client had surgery that rendered her immobile post operatively, her need during the night for a bedpan, as she was unable to communicate effectively in English, she described as a most humiliating experience, she was never approached or asked if she required the toilet.

Another area of concern identified by Gerrish et al (1996) was respect and recognition of difference. Leininger (2002) believes "human caring is a universal phenomena but the expression processes and patterns vary among cultures". The ability to show respect for a patient/client and a degree of understanding of their views, are equally essential components of care. Thus, healthcare workers displaying negative attitudes and cultural ignorance can, compromise nurse – patient/ client relationships. Gerrish et al (1996) relates the following examples; of a Gujarati woman's experience:

"attitudes which are dismissive or patronising can block communication from day one. It takes only one rough comment from one nurse or doctor to promote the perception that, that is how things are

an ethnic menu but this may not always be their first choice" (Gerrish et al 1996).

If a hospital provides an ethnic menu "it is frowned upon to bring in our own food; but often there are good reasons for our own dietary codes: say some things can be eaten only on special days; others considered strength building" (Gerrish et al 1996).

Another assumption is that "if one is Afro-Caribbean, they will eat English food, but the taste and ingredients of food are completely different" (Gerrish et al 1996). Gerrish et al (1996) found a lack of knowledge and understanding in relation to the basic need of dignity and privacy. Often, religious prescriptions or prohibition of cultures, influence for example personal hygiene and body care. An example recounted by Gerrish et al (1996) is that of an Asian women's experience, who requested to be examined by a female doctor. This request, she was advised is dependant on the availability of female doctor. Ultimately this was a great source of anxiety and stress to this woman as privacy, modesty and dignity are "absolutely essential and this is particularly true of Asian women".

The Privilege

by Bernice Glavin

I was privileged to have met an angel so fair,
Who suffered her illness without a care,
She struggled on against all odds,
Determined to battle against the Gods.

Days passed but no miracle took place,
I continued to look at that gentle face,
Hours went by and she laboured through,
Her bravery was an insight to me and you.

Despite her efforts all was grim,
Her body could no longer function within,
She gently drifted to a better place,
Where pain would not be etched on her face.

She departed this life leaving so much sorrow,
To the people left there could be no tomorrow,
That special angel now stands at God's side,
In Heaven watching over sick people far and wide.

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Somali women interviewed expressed a preference for female professionals to be their carers. One woman reported that following an episiotomy, when stitches were to be removed, "the doctor just came and did it ...they didn't ask her, so she didn't want to ask herself" while others were offered the choice of a male or female carer (Gerrish et al 1996).

Concerns expressed by recipients of this study indicate the importance of appropriate cross-cultural knowledge in the provision of appropriate sensitive care (Gerrish et al 1996). Yet in spite of the above negative patient experiences, there are some positive experiences, as recounted by an Asian carer group,

"Community nurses visit many members of our group and on the whole our experience has been very positive. When nurses work with you on a one to one basis and are coming into your home, meeting your family, observing some of the customs and enjoying food, the whole interaction is different. Maybe because they have gained experience of the Asian community first hand they have more awareness of religion, food and our way of life" (Gerrish et al 1996).

Overall, the study poses challenges for all nurses to question their practice and modify it to benefit all patients /clients seeking their care. It further highlights the need to educate nurses to provide culturally sensitive care for minority ethnic communities within society.

Cortis (2000), in a study aimed to redefine the characteristics of nursing care and to compare it with the expectations and perceived experiences of individuals expressed in a group of 38 members of a Pakistani community in Bradford, UK. This minority ethnic group identified, language, lack of cultural knowledge and lack of respect as problematic in the nurse-patient therapeutic caring relationship in the hospital setting. One person's experience forming a relationship with a nurse was related as follows:

"Nurses did try an explain things to me, I think that I did understand most of what they were saying but what bothers me is, well I think that I do not feel comfortable in asking them questions. So then, you are left more confused than you were before" (Cortis 2000).

Another person more poignantly commented: *" sometimes I saw nurses talking to white patients and sitting on their beds but not mine"* (Cortis 2000).

Some individual stories portrayed feelings of not being respected by nurses:

"I think that they need to do more care, nurses need to feel more respect for the patient, so they give them more care because they do not give them respect and they do not care about them and sometimes the patient must ask two or three times for the pain killers and sometimes nurses shout at patients" (Cortis 2000).

These experiences recounted by patients indicate that nurses focus very little on the cultural aspect of caring to the point that individuals from minority ethnic groups feel that they are being ignored. Cortis (2000) offers possible explanations for the lack of cultural sensitivity. He suggests that nurses presume that a person from another cultural background will understand and accept nursing care as prescribed to them. Cortis (2000) claims also that nurses' innate racism actually stops them from meeting and acknowledging patients' cultural needs. On the other hand, Cortis (2000) claims that learning about another culture may be a unsettling experience for many as the positive and negative aspects of their own culture are raised, thus raising one's self awareness. Yet self awareness is vital for nurses as without it, nurses' own insecurities, fears, preferences, apprehensions and prejudices can lead us to block what we, or others say or do as well as to misinterpret what we see or hear (Kagan & Evans 1995).

Cortis (2000) urges caution against offering cultural education programmes about diet, dress, religion and rituals as this may reinforce stereotyping of the minority group by the superior dominant group (Gerrish et al 1996, LeVar 1998, Leininger 2000, Culley 2001 and Anderson 2001). A possible solution to these problems according to Cortis (2000) is to conduct a very appropriate nursing assessment of the patients needs, thus endeavouring to develop a therapeutic nurse patient relationship. When nurses understand what factors affect the persons behaviour in health and illness, they are then better equipped to meet the patients needs.

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Hayes (1995) claims ethnic minority maternity services in the UK are inadequate, inaccessible and inappropriate. In a qualitative study of twenty interpreter/ link workers interviewed, all but one were immigrants from the Asian sub-continent, providing interpretative services for non-English speaking Asian women availing of maternity services in a multi-racial health district of UK. The findings of this study identified information gaps and incidents of insensitive care given to these women. Seventeen out of twenty participants identified that more information was given to English speaking women than to non-English speaking women. Most of the educational information, written or audiovisual, was available only in English. Hayes had previously performed this study in 1989. In the intervening six years, evidence suggested that ethnic minorities are being ignored, as interpretative services are the same; no improvement had occurred. Despite knowing the population distribution of that area, monitoring the needs of minority groups in relation to interpretative services had not occurred and continued on an "ad-hoc basis" (Hayes 1995). The services that are available are within normal working hours. If women required interpretative services out of hours, a relative or an employee of Asian origin would be requested to oblige, which demonstrates insensitive care.

Similarly Harkin (2001) in a discussion paper, highlights issues of inequitable access to health services for minority ethnic groups in Ireland due to lack of cultural knowledge and communication barriers on behalf of staff towards other cultures. According to Anderson et al (2001), health care professionals must become culturally aware in order to reduce inequalities in health and to serve the community more effectively. Hayes (1995) makes the point that good maternity care requires intimate and sensitive communication between the woman and those who care for her, and insisting it is the responsibility of the health services to ensure adequate provision of services. Hayes (1995) makes some recommendations to improve services to meet the needs of ethnic minority groups. Seminars based on cultural requirements of patients held on a regular basis by link workers/ interpreters. More training provided for healthcare workers to assist in caring for multiethnic communities. However Hayes did not indicate the content of the proposed training programmes. As previously discussed, information giving may contribute to bias. It is only by increasing awareness among professionals that a change in practice is likely to occur.

In summary, the main challenges identified by patients in the studies reviewed: (Hayes 1995, Gerrish et al 1996 and Cortis 2000) are language barriers, variations in demonstration of respect and dignity, and the lack of knowledge and understanding of patients/clients cultural needs in relation to health. The next section will explore registered nurse's perspective of multiethnic care.

Registered nurse's perspective of multi-ethnic care

Leininger (2002) argues that it is important to recognise one's own cultural perspective as it

fosters in one the idea that life is different for others. Lynam (1992) and Leininger (2002) note that we are all socialised to look at our experiences and situations in a particular way as a result of our social interactions with those around us, namely family, friends and work colleagues. In relation to people's health and healthcare, Boyle (1999) highlights the importance of understanding people's cultural ways of living (minority or majority ethnic groups in a population). Healthcare practitioners are a product of their own culture and so are their treatments (Boyle 1999). On reviewing the literature, the studies suggest that nurses share many common experiences, problems and challenges while caring for patients from ethnic minority groups (Murphy et al 1993 and Boyle 1999).

Murphy et al (1993) explored qualitatively, by in depth interviews, the lived experiences of eighteen trained nurses caring for minority ethnic clients in the United Kingdom. The study found five areas of concern: communication, nurse-patient relationship, relatives and nurse's feelings of frustration, stress and helplessness and lack of knowledge about cultural difference (Murphy et al 1993). All eighteen respondents identified issues of communication that traversed the above five areas. Nurses felt forming good nurse – patient relationships were compromised due to language difference. Building a good relationship needed more time than normal and if client feedback was not forthcoming then the relationship was poor. Some nurses felt that some relative's relationship with clients were poor, thus nursing care was compromised due to inaccurate translation, while others felt the presence of relatives was paramount to the client care (Murphy et al 1993). All nurses reported feeling frustrated when caring for patients from minority ethnic groups due to lack of understanding of language (Murphy et al 1993). Respondents often felt patients were frightened, unhappy or distressed but the inability of nurses to source the causes of these issues led nurses to feel stressed and frustrated. For many it was the inability to give the standard of care they felt they should, generated feelings of stress (Murphy et al 1993).

Lack of cultural knowledge was identified by Murphy et al (1993) as particularly problematic. Knowing what was acceptable and not acceptable to clients created the greatest problem and the inability to check the appropriateness of care with clients due to communication difficulties. Lack of suitable interpretative services was found to further exacerbate the communication issue. A key issue identified by the participants was that their training (initial nurse education) did not prepare them to care for ethnic minority groups (Murphy et al 1993).

When the ability to communicate effectively is greatly reduced and when this is compounded by the lack of appropriate cultural knowledge, the therapeutic relationship between the nurse and the patient may be handicapped, by a tendency for the nurse to utilise their own beliefs and values of western health standards, to care for clients of ethnic minority.

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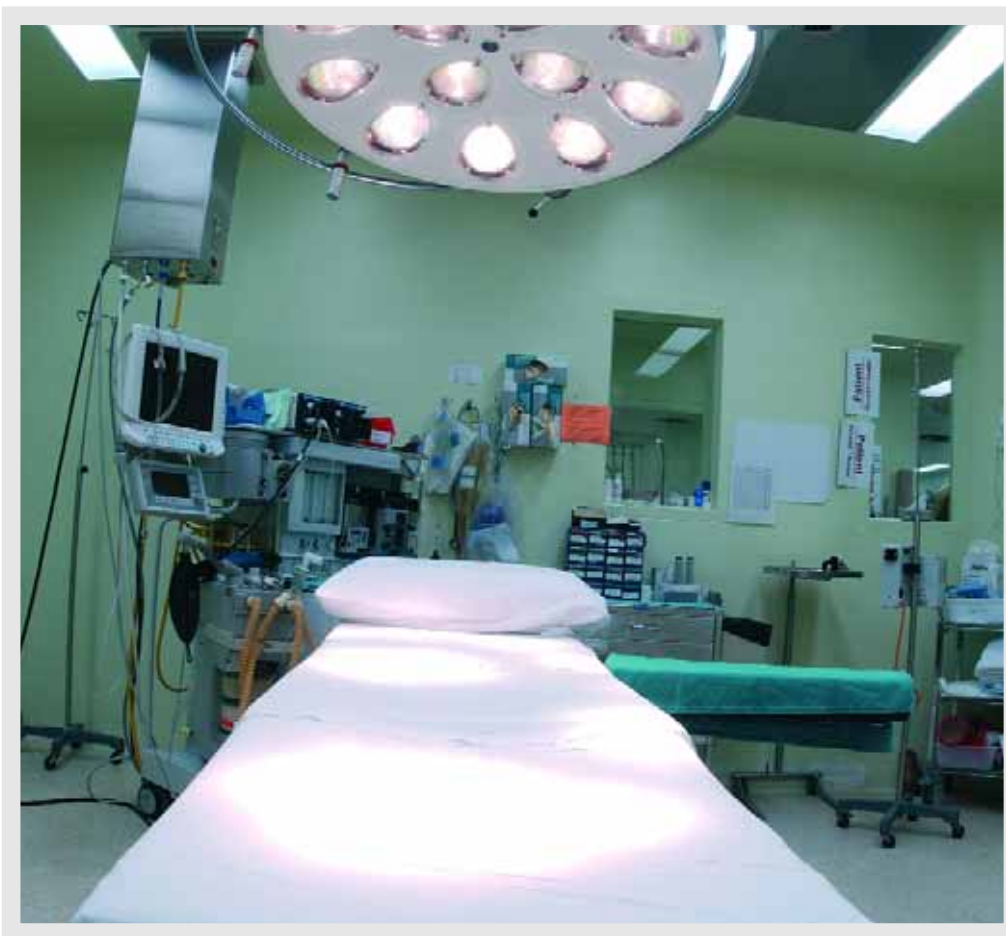
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In the management of neuraxial opioid-induced pruritus we recommend that minimal analgesic doses of opioids should be used to provide pain relief during and after surgical operations. Non Steroid Anti-inflammatory Drugs (NSAIDs) drugs may be a possible prophylactic therapy for opioid-induced pruritus. Efficacy of subhypnotic dose (10 mg), propofol as an antipruritic agent, is conflicting. Propofol either administered as a bolus (10 mg) (Borgeat, Wilder-Smith, Saiah, Rifat, 1992) or as a bolus (10 mg) followed by 30 mg/24 h infusion (Torn, Tuominen, Tarkkila, Lindgren, 1994), has been reported to be an efficient drug treatment for spinal morphine-induced pruritus after gynaecologic, orthopaedic, thoracic and gastrointestinal surgery. However, in two studies (Warwick, Kearns, Scott, 1997; Beilin, Bernstein, Zucker-Pinchoff, Zahn and Zenzen, 1998) that included women undergoing elective caesarean section including spinal morphine, propofol (10 mg) in two divided doses five minutes apart, was not efficacious. Additional

clinical studies are thus necessary to determine the optimal effective dose of propofol which is not associated with excess sedation.

5-HT₃ (Serotonin) antagonists should be the drugs of first choice. Ondansetron and propofol as prophylactic agents have been associated with minimal side-effects, furthermore ondansetron has no effect on the quality of analgesia. An added benefit of ondansetron is its ability to prevent and treat postoperative nausea and vomiting. With multiple pathways involved in the pathophysiology of pruritus combination therapy should be examined. Ondansetron and propofol seem to be the most promising agents whose antipruritic properties need to be investigated further.

Footnotes

Opioid: A scientific term denoting both natural (codeine, morphine) and synthetic (methadone, fentanyl) drugs. A type of medication related to opium. Opioids are strong analgesics

Pruritus: irritation of the skin, affecting to whole body surface or a certain area of the body.

In an Irish context, Boyle (1999) set out to examine nurse's understanding of cultural competence in nursing practice and to investigate the application of a transcultural nursing approach to nursing care. A 50-question self-report 3-section questionnaire was utilised to examine personal and professional information, training, studies and practice and the clinical experience of registered nurses (n = 38, a response rate of 76%).

Communication was identified by 55.2% as being an unsolvable problem (Boyle 1999), but as identified by Boyle (1999), 57.8% of the subjects did not know how to obtain translator services. When caring for patients of ethnic minority groups, 61.5% of nurses stated that they gathered patient information only (name, age date of birth, past medical/nursing history), but not culturally relevant information, due to lack of cultural knowledge. According to Boyle (1999) this may indicate a lack of initiative on behalf of the "nurses to educate themselves about cultural diversity" or may indicate organisational constraints, lack of available training and time to train. As this is the only Irish study available it is interesting to note that none of the 38 respondents identified Travellers as a minority ethnic group.

A limitation of the study is the lack of clarification of cultural competence, a concept debated in the literature (Purnell, L. and Paulanka, B.J. 1998, Campinha – Bacote, J. 1999 and Burford, B. 2001). It could be suggested that this study has not explored nurses understanding of cultural competence in nursing practice.

To summarise, Boyle (1999) in his study of registered nurses' cultural competence in caring for minority ethnic people in Irish hospitals identified that communication difficulties and lack of knowledge as key areas of concern, similar to those identified by Murphy et al (1993). A further point highlighted was the lack of educational preparation of nurses in their initial training to care for patients in a multiethnic society (Murphy et al 1993 and Boyle 1999). Nurses feel inadequately prepared to care for people from minority ethnic communities, thus nursing care tends to be practised in Ireland from a western bio-medical perspective (Boyle 1999). Also, nurses according to Boyle (1999), require continuous education and facilitation on culture and its influences on health and healthcare. This implies that through cultural education, student nurses and qualified nurses will become better able to care for minority ethnic communities.

A review of the literature of registered nurse perspective on multicultural care identified challenges such as communication difficulties, language difficulties, lack of translator services resulting in difficult client – nurse relationships and lack of knowledge of cultural differences as barriers to effective nursing care of ethnic minority communities (Murphy et al 1993 and Boyle 1999). Furthermore, nurses identified that

their nurse education did not prepare them to care for ethnic minority patients (Murphy et al 1993 and Boyle 1999).

Communicating with culturally diverse groups

Communication guidelines that can be used to interact with culturally diverse groups as suggested by Arnold and Boggs (2003): speak slowly and clearly, use language that the patient will understand in sentences that are as simple as possible. Ask the same basic questions in the same sequence and repeat the same phrases. Avoid the use of technical language, choose words that include cultural terms wherever possible. Use "flash cards" or picture cards of common hospital equipment e.g. glass, cup, thermometer and toilet etc. If possible, have a sheet with common hospital terms such as pain, hungry, tired, cold, hot, nurse and doctor with the patients language written on the side.

Encourage the patient by smiling and listening attentively. Never assume the patient understands because they nod or smile in the appropriate place. If possible, learn some key words of the patient's language that will relate to the patient's health situation. Teach them some English words so they can express their health needs. Identify barriers that may compromise compliance such as social values, environment and language. For patients who cannot communicate because of language barriers interpreters should be sought. The use of family relatives and children to translate is not advisable, as they may not translate directly thus reducing effective healthcare being administered. For the patient to avail of the best nursing care, specifically trained interpreters should be called upon, but keeping in mind differences in dialects as well as differences in the gender and social status. Check your hospital contact details for interpreter services.

Summary

Nurses including perioperative-nurses and patients alike share similar problems and challenges; those of effective communication, lack of cultural knowledge and understanding. Nursing is increasingly seen as being in the front line of healthcare delivery so to ensure that respectful, dignified and equitable care is delivered. Cortis and Law (2005) shares a similar view to HEEU (2002) "that anti-racism/interculturalism and diversity courses should be included as a core part of training for all" involved in healthcare delivery. The Department of Justice Equality and Law reform (2005) in the National Action Plan Against Racism recommend that health service professionals have an inter-cultural training module, which includes a focus on inter-cultural communication. Presently, health services throughout Ireland are training trainers in anti-racism and inter-culturalism, who will disseminate this information to the staff on the ground.

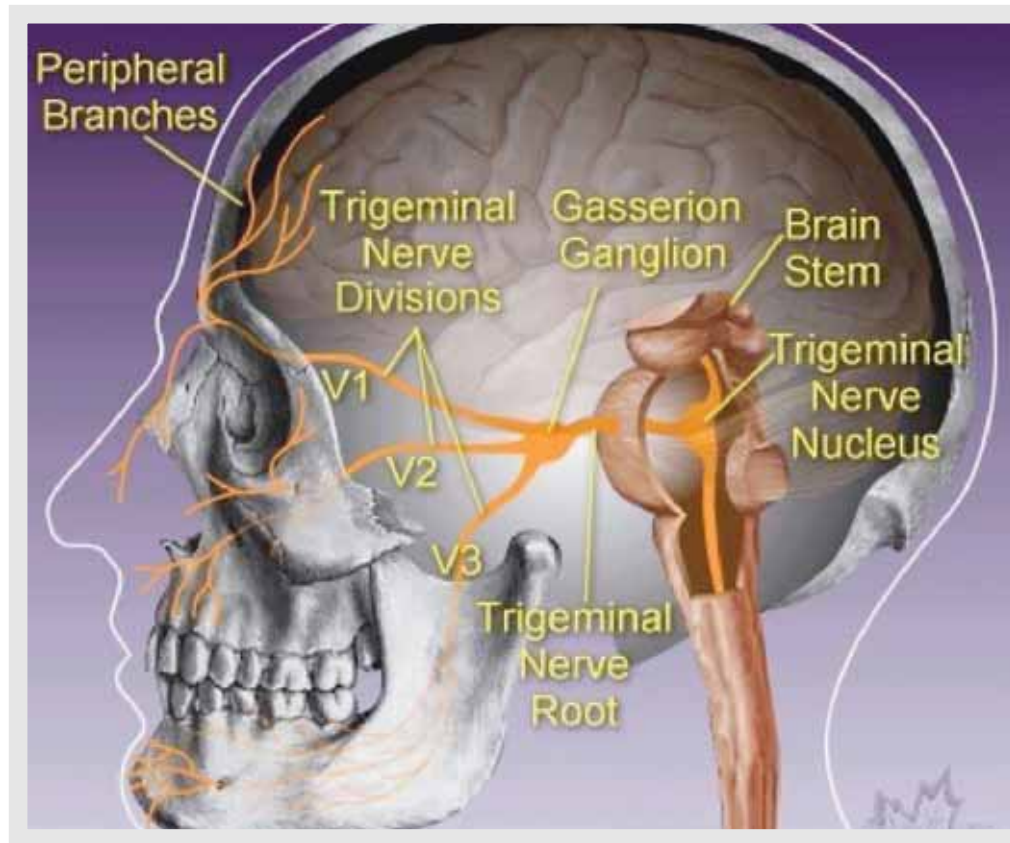
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Neuraxial Opioid-Induced Pruritus

Pain is a combination of sensory and affective (emotional) components. The sensory component of pain is referred to as nociception. Nociception is the process of transduction, transmission, perception and modulation of pain. In contrast antinociception is the degree of suspension of nociception for noxious stimuli. Antinociception refers to inhibition of the nociceptive processing in the nervous system. Analgesia is the treatment to provide antinociception. In the provision of adequate anaesthesia, the role of antinociception is crucial; it makes surgical operations possible.

Antinociception without side-effects has been a difficult problem in the history of medical science. In the 1970s, highly specific opioid receptors were discovered in the central nervous system, including the spinal cord, and it seemed to bring physicians closer to finding a solution to the problem. This, however, has not been achieved. Intrathecal and epidural anaesthesia is common in anaesthetic practice, providing successful analgesia. The beneficial effect of intrathecal morphine used either alone or in combination with local anaesthetics is to augment and prolong intraoperative and postoperative analgesia. However, a wide variety of clinically relevant side-effects have been reported. One of these side-effects is pruritus, which is a common sensation after administration of opioids. Itch is by definition a sensation that provokes the desire to scratch and can be aroused by variety of mechanical, electrical and chemical stimuli (Ballantyne, Loach and Carr, 1988). It is bothersome to the patient and sometimes may be more unpleasant than pain itself for the patient (Ballantyne, Loach and Carr, 1988).

The reported incidence of pruritus after neuraxial (epidural or intrathecal) opioid administration varies between 30-100% (Scott, Fischer, 1982; Dahlgren, Hultstrand and Jakobsson, 1997; Kyriakides, Hussain and Hobbs, 1999; Shah, Sia and Chong, 2000; Yeh, Chen and Lin, 2000; Stocks, Hallworth, Fernando, England, Columb and Lyons, 2001). Parturients (women giving birth) appear to be the most susceptible. The incidence of neuraxial opioid-induced pruritus in parturients (relating to childbirth) has been reported to be between 60-100% (Scott, Fischer, 1982; Horta, Ramos and Goncalves, 2000; Yeh, Chen and Lin, 2000) and appears to be dose dependent (Scott, Fischer, 1982; Kelly, Carabine, Mirakhur, 1998; Dahl, Jeppesen, Jorgensen, Wetterslev, Moinicke, 1999; Yeh, Chen and Lin, 2000; Horta, Ramos and Goncalves, 2000). This increased incidence may be due to an interaction of oestrogen with opioid receptors (LaBella, Kim, Temoleton, 1978; Krajnik, Zyllicz, 2001). Following major orthopaedic surgery the incidence of pruritus after intrathecal opioids is less with an incidence of between 30-60% (Torn, Tuominen, Tarkkila, Lindgren, 1994; Colbert, O' Hanlon, Chambers, Moriarty, 1999; Colbert, O' Hanlon, Galvin, Chambers, Moriarty, 1999).

Pathophysiology of neuraxial opioid-induced pruritus

The wide range in the reported incidence of neuraxial opioid-induced pruritus suggests that there may be individual patient differences that influence itch perception. This concept is further suggested by the lack of association between the dose of opioids administered neuraxially (epidural or intrathecal administration) and intensity with which pruritus is perceived by patients, and by the absence of the symptom in some patients receiving neuraxial opioids. More than one mechanism may participate in the development of neuraxial-opioid induced pruritus.

Receptors in the skin

The sensation of itch arises from the superficial layers of the skin, the mucous membranes and the conjunctivae (Teofoli, Procacci, Maresca, Lotti, 1996). It is postulated that a modified type of C-fiber (nerve/neurone), may represent the afferent units mediating itch sensation (Schmelz, Schmidt, Bickel, Handwerker and Torebjork, 1997).

Mediators

Morphine produces part of its analgesic effect through the release of serotonin (Krajnik and Zyllicz, 2001). It has also been suggested that prostaglandin (PGE1 and PGE2) release may be associated with neuraxial opioid-induced pruritus. Prostaglandins (PGE1 and PGE2) enhance C fiber transmission to the central nervous system (Krajnik and Zyllicz, 2001). They are also known to release histamine and to potentiate pruritus induced by histamine.

Central mechanisms of spinal opioid - induced itch The reported incidence of pruritus after intrathecal morphine is 62 – 85 %, epidural morphine is 65 – 70 %, intrathecal fentanyl 67-100 %, epidural fentanyl 67 %, intrathecal sufentanyl 80%, epidural sufentanyl 55% respectively (Kjellberg, Tramer, 2001). After intrathecal administration, opioids reach peak concentrations in the cerebrospinal fluid almost immediately (Chauvin, Samii, Schermann, Sandouk, Bourdon, Viars 1982). Following epidural administration there is a delay in rise to peak concentration (10 to 20 minutes with fentanyl and one to four hours with morphine) (Gourlay, Murphy, Plummer, Kowalski, Cherry, Cousins, 1989). Receptors which mediate the pruritus associated with morphine administration are likely to be the μ -opioid receptor.

Facial areas innervated by the trigeminal nerve are predominantly affected. The distribution of itching in such a fashion is likely to be due to cephalad (upward) spread of opioids in the cerebrospinal fluid and subsequent interaction with the trigeminal nucleus and nerve roots (Ballantyne, Loach, Carr, 1988; Krajnik, Zyllicz, 2001). Pruritus following intrathecal opioid administration, is typically in the nose and upper part of face regions (Figure 1) (Scott, Fischer, 1982).

Koenigstein has described the presence of an itch centre in the lower medulla that includes the trigeminal nucleus (Koenigstein, 1948). Opioid administration into the cerebral ventricles also induces behavioural excitation that is not reversible with naloxone (Koenigstein, 1948; Yaksh, Harty, Onofrio, 1986). It is thus postulated that central nervous system excitation may be due to mechanisms other than opioid receptor activation. This property of opioids may also participate in the pathophysiology of itch (Yaksh, Harty, Onofrio, 1986).

Opioid antagonism of inhibitory neurotransmitters gamma amino butyric acid (GABA) and glycine in the central nervous system maybe a possible mechanism of opioid-induced pruritus (Ballantyne, Loach, Carr, 1988; Krajnik, Zyllicz, 2001).

Conclusion

Although pruritus after neuraxial administration of opioids is a common side-effect, to date, few studies have elucidated the mechanisms, mediators, neural pathways and pathophysiology of this symptom. We agree with Kjellberg and colleagues (2001), who analysed twenty-two trials of drugs used in the treatment and prevention of opioid-induced pruritus, that the quality and the amount of data from these trials is not satisfactory. The fact that pruritus is an entirely subjective sensation and that the discussion of skin itching will make some individuals scratch, can make study design of the effectiveness of an antipruritic agents difficult. A better understanding of the pathophysiology would lead to improved preventative and treatment strategies.

The current therapeutic strategies for spinal opioid-induced pruritus are unsatisfactory (Kam, Tan, 1996). Several agents from numerous drug families have been employed but none has proved to be totally effective. Recent insights into pathophysiological mechanisms may offer promising developments in the prevention of neuraxial opioid-induced pruritus.

Pharmacological Agents	Mechanism	Site of Action
Opioid antagonists	μ -receptor inhibition	Medullary dorsal horn, nucleus trigeminalis
Propofol	Depression of nerve Transmission	Medullary dorsal horn
Non-steroidal Anti-Inflammatory Drugs	Cyclooxygenase enzyme Inhibition	Endoplasmatic Reticulum of Macrophages
Droperidol	Depression of nerve transmission	Medullary dorsal horn, nucleus trigeminalis
5-hydroxytryptamine type 3(5-HT ₃)	5-HT ₃ receptor inhibition	Medullary dorsal horn Nucleus Trigeminalis

Table 1 The treatment and prevention of neuraxial induced-pruritus, mechanisms and sites of action

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