About IJMA [last updated July, 1st, 2021]

- International Journal of Medical Arts is the Official Journal of the Damietta Faculty of Medicine, Al-Azhar University, Egypt
- It is an International, Open Access, Double-blind, Peer-reviewed Journal
- Published four times a year
- The First Issue was published in July 2019
- Published under the following license: Creative Commons Attribution-ShareAlike 4.0 International Public License (CC BY-SA 4.0). It had updated from the Creative Commons license [CC BY] in volume 2, Issue 4, October 2020
- The Egyptian Knowledge Bank hosts the web site of IJMA
- The Egyptian Knowledge Bank supports IJMA
- IJMA follows the regulations of the International Committee of Medical Journal Editors
- IJMA is indexed in the “Directory of Open Access Journals” [15 January 2021].
- IJMA is indexed in JGate [29-6-2021]
- IJMA is a member of the International Society of Managing and Technical Editors
- IJMA introduced to the search engine [BASE] through DOAJ
Ketamine versus Dexmedetomidine in Local Wound Infiltration for Postoperative Pain Relief in Cesarean Section

Nourhan R. Biomy [1], Asmaa Fathelbab [2], Amina Abdel-Fattah [2], Abeer E. Farhat [3]

1 Department of Obstetrics and Gynecology, El Hawamdyia General Hospital, Ministry of Health, Egypt.
2 Department of Obstetrics and Gynecology, Faculty of Medicine, Al-Azhar University, Egypt.
3 Department of Anesthesia and Intensive Care, Faculty of Medicine for Girls, Al-Azhar University, Egypt.

Corresponding author: Amina Abdel-Fattah
amona_update@yahoo.com

Received: June 20, 2021; Accepted: July 17, 2021.

ABSTRACT

Background: Cesarean delivery is a frequently obstetric operation in Egypt with a recently reported overall cesarean section rate of 54% and it causes moderate to severe postoperative discomfort. Infiltration of the wound site is a method to improve postoperative analgesia.

The aim of the work: To compare the pain relief effects of ketamine versus dexmedetomidine combined to bupivacaine in local wound infiltration in patients undergoing cesarean section and to estimate side effects of medications.

Patients and Methods: This randomized, controlled study including 90 women were subjected for elective cesarean delivery under general anesthesia and were divided at random into 3 equal groups to receive 40 ml bupivacaine [0.25%] + either 2 mg/kg ketamine in [group A], 2 μg/kg dexmedetomidine in [group B] or 2 ml saline in [group C] via local wound infiltration. The primary outcome was the time of the first analgesia requested. The secondary outcomes were total dose of analgesia per 24 hours, visual analogue scale, the time of starting movement, breast-feeding, passing flatus or stool, start of eating and adverse effects of medications.

Results: A significant increase in time of the first analgesic request in group A [8.4 ±1.91 h. and group B [7.5±1.81] h. than group C [4.3±1.24] h. A significant decrease in pethidine consumption in group A [59 ± 28.93 mg] than group B [72 ± 23.1 mg] and group C [102 ±16 mg]. The visual analogue scale [VAS] was significantly lower [p<0.001] in groups A and B than in group C. The time of start movement, breast-feeding, passing flatus and eating was decreased in groups A and B than in group C

Conclusions: Addition of ketamine or dexmedetomidine to local anesthetics wound infiltration increased time to the first analgesia request and decreased total analgesic consumption, but ketamine is superior.

Keywords: Ketamine; Dexmedetomidine; Local anesthesia; Wound Infiltration.

This is an open-access article registered under the Creative Commons, ShareAlike 4.0 International license [CC BY-SA 4.0] [https://creativecommons.org/licenses/by-sa/4.0/legalcode.

INTRODUCTION

Post-cesarean pain is unpleasant sensation that occurs as a result of tissue damage, and indicates that the body has been injured [1].

Post-operative pain management is essential since women are expected to recover rapidly and care for their newborns within a few hours following surgery [2]. As a result, utilizing a safe, uncomplicated, and effective analgesic is recommended [3].

Effective postoperative analgesia can enhance recovery and decrease morbidity [4]. Local anesthetics wound infiltration is an adequate technique for pain management after many operations and can decrease postoperative analgesic requirements [5].

It is an easy, effective and costless technique can enhance postoperative analgesia for different types of operations without major complications [6].

In terms of somatic pain control, a variety of systemic and local anesthetic approaches have been employed to treat Post-cesarean pain [7].

Ketamine is a central and peripheral analgesic that works by blocking the N-methyl-D-aspartate [NMDA] receptor [8].

Dexmedetomidine is a highly selective agonist of α 2-adrenergic receptor with sedative, analgesic but not anesthetic characters. So, it’s safe as an adjuvant in various clinical applications [9].

AIM OF THE WORK

In the current work, we aimed to compare the pain relief effects of ketamine versus dexmedetomidine combined to bupivacaine in local wound infiltration in patients underwent cesarean section and to estimate side effects of medications.

PATIENTS AND METHODS

Following the approval of the local ethics committee and the signed informed consent of each parturient, this randomized double-blind controlled study was conducted on 90 women American Society of Anesthesiologists [ASA] I and II. They were subjected to elective cesarean delivery under general anesthesia in Al-zahraa University Hospital from January 2019 to January 2020.

Inclusion criteria for pregnant women were, primigravida with singleton fetus, age between 20 and 40 years, weight between 60 and 85 kg and height between 155 and 170 cm, patients with no obstetric complication [pre-eclampsia and antepartum hemorrhage].

Exclusion criteria were patient refusal, multiple pregnancy, the procedure lasted more than one hour, drug abuse, history of allergy to the study drugs, diabetes mellitus, heart, liver, kidney, coagulation or mental disorders and local infection of previous cesarean scar.

Pre-operative assessment was done for each parturient before cesarean section by history [personal, medical, surgical, obstetric], examination [general, local and airway] and routine investigations. Each parturient was trained on the use of visual analogue scale [VAS] by an anesthesia-logist who was not involved in the study. Visual analogue scale, which was used for pain assessment is a horizontal line, 10 cm in length ranging from 0 = [no pain] to 10= [worst pain].

A computer-generated random number was used to allocate the patients into one of the three groups: Group A [n=30]: given 40 mL of bupivacaine [0.25%] + 2 mg/kg ketamine by local wound infiltration. Group B [n=30]: given 40 mL bupivacaine [0.25%] +2 μg/kg dexmedetomidine by local wound infiltration. Group C [n=30]: given 40 mL bupivacaine [0.25%] + 2 ml saline by local wound infiltration.

Drugs used in wound infiltration were prepared by anesthesia residents who had no rule in the study.

In the operating room, intravenous cannula was inserted and ringer acetate solution [10 ml/kg/h] was started, patients were attached to the standard monitor [Fabius Gs, Germany] as electrocardiography, pulse oximetry and non-invasive blood pressure. Prior to the induction of anesthesia, the mother’s heart rate [HR] and mean arterial pressure [MAP] were monitored.

After preoxygenation [for five minutes], women received general anesthesia by intravenous propofol [1.5 mg/kg], atracurium [0.5 mg/kg]. The maintenance of anesthesia was achieved by oxygen/ air mixture, sevoflurane [2%], atracurium [0.1 mg/kg] if required and fentanyl 50 μg, after delivery of the fetus, HR and MAP were recorded each 10 minutes interval through the surgery.

Before wound closure, women received intra-incisional infiltration of 40 ml bupivacaine [0.25%] plus either 2 mg/kg ketamine in [group A], 2 μg /kg dexmedetomidine in [group
B) or 2 ml saline in [group C] through infiltration in the
anterior and posterior layer of the rectus sheath [trans-
versalis fascia and parietal peritoneum], subcutaneous
tissue and skin on upper and lower edges of surgical
wound. At the end, neostigmine [0.04-0.06 mg/kg] and
atropine [0.01 mg/kg] were used to counteract
neuromuscular blockade. Women were sent to the post-
anesthesia care unit [PACU] for a continued surveillance
after extubation. HR and MAP were measured every 30
minutes post-operative until the patient was discharged
from [PACU].VAS was used to assess pain at 1, 2, 3, 4, 6, 8, 12, 18, and 24 h postoperatively. Visual
analogue scale ≥4 was treated with meperidine 0.5 mg/kg intravenous.

The time of the first analgesic request, total dose of
analgesic consumption per 24 hours, time to start
movement, breast-feeding, eating and passing flatus or
stool and side effects of medications were recorded
[nausea, vomiting, bradycardia and hypotension]. Heart
rate < 60 b/min was managed by intravenous atropine
[0.5 mg], MAP drops > 20% of baseline value was managed by
intravenous fluid and intravenous ephedrine 6-12 mg.
Ondansetron 4 mg was used to treat nausea and vomiting.

Statistical analysis

The data was collected and analyzed by IBM SPSS
v23 [Armonk, NY, USA]. The mean, standard deviation
[SD] and median Interquartile range [IQR]* were used to
express quantitative data. Qualitative information
presented as a number or %. The One-Way ANOVA test
was used to compare more than two groups using
quantitative data and parametric distribution, with post hoc
analysis by least significant differences [LSD]. While
Kruskall Wallis test was used for data with a non-
parametric distribution. Confidence interval 95% and error
margin 5%. Statistical significance if P value less than
0.05.

RESULTS

In this study, 126 women were assessed for eligibility,
29 women did not meet the criteria and 7 women refused
to participate in the study. The remaining 90 women were
randomly assigned to three equal groups. The
demographic data and the duration of surgery were
comparable between groups being studied [P-value >0.05],
as shown in table 1.

Table [2] reveals significant increase in the time of the
first analgesic request in group A [8.4 ±1.91 h] and group
B [7.5±1.81 h] than group C [4.3±1.24 h]. A significant
decrease in pethidine consumption in group A [59.0±
28.93 mg] than group B [72.0±23.1 mg] and group C
[102.0 ± 16.9 mg].

The visual analogue scale was significantly reduced in
group A and B than in group C, but group A was superior
[Table 3].

Table [4] is showing a reduction in the time of start
breast-feeding, passing flatus or stool, start of eating and
movement in group A and group B than in group C.

Table [5] demonstrates that group B had much more
bradycardia than group A and group C [P=0.003], whereas
no significant difference was detected for nausea and
vomiting or hypotension.

Table [1]: The demographics of the study groups.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age [years]</td>
<td>Mean±SD</td>
<td>29.40 ± 5.37</td>
<td>30.47 ± 5.89</td>
<td>30.43 ± 6.33</td>
<td>0.347</td>
<td>0.708</td>
</tr>
<tr>
<td></td>
<td>Range</td>
<td>21 – 40</td>
<td>20 – 39</td>
<td>21 – 40</td>
<td>2.156</td>
<td>0.122</td>
</tr>
<tr>
<td>Weight [kg]</td>
<td>Mean±SD</td>
<td>72.13 ± 8.31</td>
<td>69.63 ± 7.19</td>
<td>73.87 ± 8.27</td>
<td>1.446</td>
<td>0.241</td>
</tr>
<tr>
<td></td>
<td>Range</td>
<td>60 – 85</td>
<td>60 – 63</td>
<td>61 – 85</td>
<td>1.446</td>
<td>0.241</td>
</tr>
<tr>
<td>Height [cm]</td>
<td>Mean±SD</td>
<td>163.80 ± 9.10</td>
<td>163.27 ± 4.73</td>
<td>161.90 ± 4.54</td>
<td>0.577</td>
<td>0.564</td>
</tr>
<tr>
<td></td>
<td>Range</td>
<td>157 – 170</td>
<td>156 – 170</td>
<td>155 – 169</td>
<td>0.577</td>
<td>0.564</td>
</tr>
<tr>
<td>The duration of surgery [min]</td>
<td>Mean±SD</td>
<td>44.67 ± 9.76</td>
<td>46.70 ± 10.08</td>
<td>47.17 ± 8.89</td>
<td>0.07</td>
<td>0.04</td>
</tr>
<tr>
<td></td>
<td>Range</td>
<td>30 – 60</td>
<td>31 – 60</td>
<td>31 – 60</td>
<td>0.07</td>
<td>0.04</td>
</tr>
</tbody>
</table>

Table [2]: Comparison of the three groups in terms of the first analgesic requirement and total pethidine consumption.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The first analgesic requirement [h]</td>
<td>Mean ± SD</td>
<td>8.4 ± 1.91</td>
<td>7.5 ± 1.81</td>
<td>4.3 ± 1.24</td>
</tr>
<tr>
<td></td>
<td>Range</td>
<td>6-12</td>
<td>5-10</td>
<td>3-6</td>
</tr>
<tr>
<td>Total pethidine consumption [mg]</td>
<td>Mean ± SD</td>
<td>59±28.93</td>
<td>72±23.1</td>
<td>102±16.9</td>
</tr>
<tr>
<td></td>
<td>Range</td>
<td>30-120</td>
<td>30-120</td>
<td>60-120</td>
</tr>
</tbody>
</table>

P1: P value between group A and group B; P2: P value between group A and group C, P3: P value between group B and group C. P-value <0.05: Significant.
ketamine and dexmedetomidine in local wound infiltration analgesia for different types of operations without major and costless technique can enhance the gastrointestinal motility's recovery of stress of surgery and postoperative pain. Hypotension Bradycardia Variable

Table [4]: Comparison between the three groups regarding the time of start breast-feeding, passing flatus or stool and start of eating and movement.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Time of start breast-feeding [h.] Mean±SD</td>
<td>3.33 ± 1.21</td>
<td>3.67 ± 1.03</td>
<td>4.57 ± 1.19</td>
<td>9.262</td>
<td>0.000</td>
<td>HS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>2 – 5</td>
<td>2 – 5</td>
<td>3 – 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time of passing flatus or stool and start of eating [h.] Mean±SD</td>
<td>4.63 ± 1.75</td>
<td>5.23 ± 2.14</td>
<td>6.23 ± 1.79</td>
<td>5.401</td>
<td>0.006</td>
<td>HS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>2 – 7</td>
<td>2 – 8</td>
<td>3 – 9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time of start movement [h.] Mean±SD</td>
<td>3.53 ± 1.17</td>
<td>3.83 ± 0.99</td>
<td>4.63 ± 1.16</td>
<td>7.917</td>
<td>0.001</td>
<td>HS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>2 – 5</td>
<td>2 – 5</td>
<td>3 – 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table [5]: Adverse effects of medications in the study group.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>3</td>
<td>10.0%</td>
<td>3</td>
<td>10.0%</td>
<td>4</td>
<td>13.3%</td>
</tr>
<tr>
<td>Vomiting</td>
<td>1</td>
<td>3.3%</td>
<td>1</td>
<td>3.3%</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Bradycardia</td>
<td>0</td>
<td>0.0%</td>
<td>7</td>
<td>23.3%</td>
<td>1</td>
<td>3.3%</td>
</tr>
<tr>
<td>Hypotension</td>
<td>0</td>
<td>0.0%</td>
<td>2</td>
<td>6.7%</td>
<td>2</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

DISCUSSION

Effective postoperative analgesia can prevent hormonal, metabolic and cardiovascular responses to the stress of surgery and postoperative pain [9]. Although, the gold standard for pain relief is an opioid, it increases postoperative nausea and vomiting and slow the gastrointestinal motility's recovery [10]. Local anesthetics wound infiltration is an easy, effective and costless technique can enhance postoperative analgesia for different types of operations without major complications [9].

This study was designed to assess the efficacy of ketamine and dexmedetomidine in local wound infiltration on pain relief in patients underwent cesarean section. Regarding the time to the first request analgesia, it was longer in group A and group B than in group C. This reflects the efficacy of ketamine and dexmedetomidine to provide adequate and extensive analgesia in local wound infiltration, which may be attributed to the synergistic effect of these drugs on combination with bupivacaine, but ketamine provided the longest time with superior analgesia. A significant decrease in total pethidine consumption in group A than group B and group C had been reported.

In agreement with our results, Mohamed et al. [8] reported prolonged time to the first analgesic request and less morphine consumption in ketamine and dexmedetomidine groups compared with the control group in major abdominal cancer surgery.

The results of our study were in accordance with the result of Kaler et al. [11] who reported prolonged time for the

---

Table [3]: Comparison among the three groups with respect to VAS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1hr Median (IQR)</td>
<td>0 (0–1)</td>
<td>0.5 (0–1)</td>
<td>1 (0–3)</td>
<td>1.813</td>
<td>0.043</td>
<td>0.315</td>
<td>0.021</td>
<td>0.037</td>
</tr>
<tr>
<td>2hr Median (IQR)</td>
<td>0 (0–1)</td>
<td>0.5 (0–2)</td>
<td>2 (1–3)</td>
<td>2.215</td>
<td>0.033</td>
<td>0.214</td>
<td>0.042</td>
<td>0.038</td>
</tr>
<tr>
<td>3hr Median (IQR)</td>
<td>1 (0–2)</td>
<td>1 (0–3)</td>
<td>3 (2–4)</td>
<td>2.452</td>
<td>0.021</td>
<td>0.715</td>
<td>0.007</td>
<td>0.032</td>
</tr>
<tr>
<td>4hr Median (IQR)</td>
<td>1 (0–2)</td>
<td>2 (1–3)</td>
<td>3 (2–5)</td>
<td>4.315</td>
<td>0.007</td>
<td>0.072</td>
<td>0.011</td>
<td>0.027</td>
</tr>
<tr>
<td>6hr Median (IQR)</td>
<td>2 (1–3)</td>
<td>3 (2–4)</td>
<td>4 (3–6)</td>
<td>5.215</td>
<td>0.001</td>
<td>0.213</td>
<td>0.001</td>
<td>0.021</td>
</tr>
<tr>
<td>8hr Median (IQR)</td>
<td>2 (1–3)</td>
<td>3.5 (3–5)</td>
<td>5 (4–7)</td>
<td>4.325</td>
<td>0.027</td>
<td>0.412</td>
<td>0.009</td>
<td>0.017</td>
</tr>
<tr>
<td>12h Median (IQR)</td>
<td>4 (3–6)</td>
<td>5 (4–7)</td>
<td>6 (5–7)</td>
<td>2.314</td>
<td>0.031</td>
<td>0.089</td>
<td>0.037</td>
<td>0.092</td>
</tr>
<tr>
<td>18h Median (IQR)</td>
<td>3 (1–3)</td>
<td>3 (2–4)</td>
<td>3 (2–4)</td>
<td>1.123</td>
<td>0.321</td>
<td>0.514</td>
<td>0.413</td>
<td>0.364</td>
</tr>
<tr>
<td>24h Median (IQR)</td>
<td>3 (2–5)</td>
<td>3 (2–5)</td>
<td>3 (2–5)</td>
<td>0.762</td>
<td>0.613</td>
<td>0.614</td>
<td>0.346</td>
<td>0.369</td>
</tr>
</tbody>
</table>

P-value < 0.05: Significant. [P1: Comparison between group A and group B, P2: Comparison between group A and group C and P3: Comparison between group B and group C.]

P-value < 0.05: Significant. The information is displayed as number [%].
first rescue analgesia in the ketamine group, with reduced total opioid consumption in lower segment cesarean section.

Also, Mitra et al. found a longer time to the first rescue analgesia in the dexmedetomidine group, and less diclofenac consumption in lumbar discectomy surgeries.

In line with our findings, Garg et al. reported that pain-free periods were longer with the ketamine & dexmedetomidine group than the control group with a significant decrease in the total analgesia required in spine surgery.

In agreement with our results, Ülgey et al. found that dexmedetomidine reduced time of rescue analgesic and total morphine consumption in total abdominal hysterectomy.

On the contrary, Medhat et al. reported no difference between the study groups regarding the time of the first analgesic request and opioid consumption in the subcostal transversus abdominis plane block in laparoscopic cholecystectomy. This may be attributed to the use of a small dose of ketamine [0.5 mg/kg] while we used [2 mg/kg] in our study.

Regarding visual analogue scale, it was significantly reduced in group A & B than group C, but ketamine was associated with superior analgesia.

In agreement with these findings, Mohamed et al. reported a significant reduction in visual analogue scale in ketamine and dexmedetomidine groups than the control group in abdominal hysterectomy.

In addition, Tuchscherer et al. demonstrated that ketamine [2mg/kg] subcutaneous infiltration provides adequate analgesia with lower visual analogue scale after cholecystectomy.

Also, Azemati et al. concluded that an addition of dexmedetomidine to ropivacaine infiltration decreased post-inguinal herniorrhaphy pain without side effects.

Liu et al. concluded that local anesthetic wound infiltration alone without adjuvants provides short-time analgesia postoperatively.

On the contrary, Medhat et al. reported that insignificant difference was found between bupivacaine versus bupivacaine ketamine groups regarding visual analogue scale after laparoscopic cholecystectomy.

In the current study, early time of starting breast-feeding, time of passing flatus or stool and start of eating and time of starting movement were significantly higher among ketamine and dexmedetomidine groups than the control group.

Kaler et al. reported that local anesthetic wound infiltration provides early ambulation, breast-feeding and passing flatus in the ketamine plus levobupivacaine group more than the levobupivacaine alone group.

Mohamed et al. reported an insignificant difference among ketamine and dexmedetomidine groups regarding the time of starting movement.

Regarding side effects of medication, we observed 7 patients [27%] with bradycardia in group B versus one patient [4%] in group C while nil in group A. This could be attributed to the fact that dexmedetomidine has central inhibition of sympathetic outflow and decrease of noradrenaline leading to bradycardia and hypotension.

No statistically significant difference was reported regarding nausea, vomiting, hypotension, dizziness, or hallucination.

Mohamed et al. concluded that there were insignificant differences among the studied groups regarding side effects.

Garg et al. demonstrated few patients in the ketamine group had nausea, dizziness, and diplopia, but statistically insignificant.

Conclusion: Ketamine in local wound infiltration was superior to dexmedetomidine as ketamine increased time to the first analgesia required and decreased total analgesic consumption.

Conflict of interest

All authors declare that there was no possible conflict of interest.

REFERENCES


