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ABSTRAK


Kata Kunci: blok fascia pecto-intercostal; sternotomi; manajemen nyeri
**ABSTRACT**

Median sternotomy in children produces moderate to severe acute postoperative pain and associated with various postoperative adverse events. Ultrasound-guided pecto-intercostal fascial block has a potential analgesic effect for median sternotomy and may give benefits in the pediatric population. We present a case of a three and a half years old boy, with anterior mediastinal tumor underwent median sternotomy and tumor excision. He was assessed with American Society of Anesthesiologists (ASA) physical status 2, segment 2 and 3 right lung fibrosis with history of lung tuberculosis. Anterior mediastinal tumor excision via median sternotomy was successfully facilitated with combined general anesthesia and bilateral pecto-intercostal fascial block, and postoperative course was uneventful. This interfascial plane block may provide adequate pain control for median sternotomy in conjunction with other modalities.

**Keywords:** pecto-intercostal fascial block; sternotomy; pain management
INTRODUCTION
Median sternotomy produces moderate to severe acute postoperative pain on the first day after surgery.\textsuperscript{1} Sternotomy pain is associated with postoperative adverse events, such as pulmonary complications, tachycardia, and persistent (or chronic) postsurgical pain.\textsuperscript{2,3} Pediatric patients are special population that requires special consideration. Common pain management for median sternotomy in children includes opioids, nonsteroidal anti-inflammatory drugs, and regional analgesia. Systemic opioids are generally used as the primary analgesic agent, and the use of regional analgesia is not widely accepted due to technical and safety issues in children. Pediatric population may receive benefits from the use of ultrasound-guided peripheral regional analgesia. Pecto-intercostal fascial block (PIFB) is an ultrasound-guided regional analgesia that was introduced in 2014 by de la Torre et al. for breast analgesia and intended to block several anterior cutaneous branches of intercostal nerves.\textsuperscript{4} PIFB has been described in adults for various indications. However, there are minimal supportive evidence to explore its usages and advantages in children.

CASE PRESENTATION
Authors present a case of three and a half years old boy, 13 kg of body weight, with anterior mediastinal tumor underwent median sternotomy and tumor excision. Thorax CT scan revealed right paracardial mass sized 1.5 cm x 1.8 cm x 3.3 cm. He was assessed with physical status ASA 2, segment 2 and 3 right lung fibrosis with history of lung tuberculosis and was declared treatment completed nearly six months ago. No shortness of breath and limitation in daily activities. His parents were fully informed and gave written informed consent for the use of the figure and case description.

Intravenous (IV) midazolam 0.5 mg and ketamine 5 mg were administered as premedication. The patient was induced using propofol 25 mg IV and fentanyl 25 mcg IV, and tracheal intubation was facilitated by atracurium 7.5 mg IV. General anesthesia was maintained with sevoflurane 2-2.5 vol% and 60% oxygen mixed with compressed air. After induction of general anesthesia and central venous catheter placement, with patient in supine position, skin was disinfected, and a high-frequency linear probe of Mindray M7 (Mindray, Shenzhen, China) was placed parallel to longitudinal axis of sternum on lateral border and scanned laterally to identify 4th and 5th costal cartilage (Figure 1a). The pectoralis major muscle (PMM), internal intercostal muscle (IIM), transversus thoracis muscle (TTM), ribs, and pleura were identified. Color Doppler ultrasonography was used to determine perforating branches of internal thoracic artery, which travel anteriorly through the anterior chest wall, piercing the intercostal

![Image](image_url)

**Figure 2.** a. Ultrasound-guided PIFB: probe and needle position, in-plane approach, a caudal-to-cranial direction; b. The needle tip is positioned in the interfascial plane between the PMM and IIM. Notes: white arrow, needle; yellow head arrow, pleura. Abbreviations: CC, costal cartilage; IIM, internal intercostal muscle; PMM, pectoralis major muscle; TTM, transversus thoracis muscle.
Figure 2. PIFB during the local anesthetic injection. Notes: blue-shaded area, local anesthetic; white arrow, needle; yellow head arrow, pleura. Abbreviations: CC, costal cartilage; IIM, internal intercostal muscle; PMM, pectoralis major muscle; TTM, transversus thoracis muscle.

DISCUSSION

Postoperative pain remains a problem following median sternotomy, particularly in pediatric patients who are special population that requires additional considerations. Excessive postoperative sternotomy pain reduces patient satisfaction and may lead to pulmonary complications, prolonged length of stay, and persistent (chronic) postsurgical pain. Several efforts have been done in order to manage postoperative sternotomy pain in pediatric population, such as minimally invasive surgery, multimodal analgesia, and regional anesthesia.1–3 Systemic opioids are conventionally used as primary analgesic agent for pain management in children undergoing median sternotomy.3 Unfortunately, opioid administration is associated with respiratory depression, prolonged sedation, and delayed extubation. The application of regional analgesia has become popular to reduce the opioid dose and side effects. Regional analgesia blocks the afferent impulses and has been shown to decrease pain and opioid requirements.3,5 Several regional analgesia techniques, such as neuraxial, paravertebral block (PVB), erector spinae plane block (ESPB), parasternal intercostal block, pecto-intercostal fascial block, transversus thoracis muscle plane (TTP) block, and wound infiltration/infusion have been used for sternotomy pain management.3 In PIFB, local anesthetic is placed in the
interfascial plane between PMM and IIM to block several anterior cutaneous branches of intercostal nerves. The anterior cutaneous branches are terminal branch of intercostal nerves, which innervate sternum and skin near midline of anterior chest wall. They pierce intercostal muscles and PMM and divide into medial and lateral branches that extend over sternum and PMM respectively. The number of injections depends on local anesthetic spreading in the interfascial plane.\textsuperscript{4,6} Compared to other regional analgesia techniques bilateral PIFB is more beneficial based on several reasons such as, 1) PIFB is performed in supine position; therefore less manipulation is required as in neuraxial technique, PVB, and ESPB, 2) avoidance pleural puncture due to superficial target of local anesthetic placement and costal cartilage as barrier to needle advancement, compared to TTP block. In the other side, the transversus thoracis muscle in TTP block for pediatrics may be challenging to observe, 3) bilateral PIFB requires only one injection on each side, in contrast, parasternal intercostal block needs multiple injections, 4) bilateral PIFB can be used as intraoperative analgesia if performed before surgical incision, and 5) use of ultrasonography improves safety by provides visualization of soft tissues, vessels, bone, and adjacent structures; real-time visualization of needle movement and local anesthetic distribution; may avoid undesirable pleural and vessel punctures, and reduce amount of local anesthetics.

**CONCLUSION**

Compared to other regional analgesia techniques, bilateral PIFB is considered as an easy procedure and may provide safe and effective pain management for median sternotomy, particularly in pediatric population, which in turn improves patient satisfaction, clinical outcomes, minimize pain- and opioid-related postoperative adverse events. Several advantages of PIFB may increase the use of regional analgesia in children. However, further studies are required to verify safety and effectiveness of PIFB in pediatric population.

**CONFLICT OF INTEREST**

None.

**REFERENCE**