

## Comparative analysis of intrathecal dexmedetomidine and fentanyl as an adjuvant to isobaric levobupivacaine in orthopaedic surgery

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### Abstract

**Aim:** to compare a combination of isobaric Levobupivacaine with fentanyl and dexmedetomidine for the characteristics of spinal blockade with respect to onset, duration and hemodynamic parameters and side effect. **Material and methods:** This was a prospective, randomized, and double blinded clinical comparative study conducted in the Department of Anaesthesiology, Jawaharlal Nehru medical college and hospital Bhagalpur, Bihar, India from march 2019 to February 2020. The study population consisted of 150 adult patients who were classified as American Society of Anesthesiologists (ASA) physical status I or II, undergoing elective lower limb orthopaedic surgery under spinal anesthesia. The study participants were randomly divided into three groups. Group A: 0.5% Levobupivacaine Isobaric 2.5ml+ 0.5ml normal saline (total volume is upto 3.0 ml). Group F: 0.5% Levobupivacaine Isobaric 2.5ml + 25mcg fentanyl (test solution will diluted with normal saline to total volume of 3.0ml). Group D: 0.5% Levobupivacaine isobaric 2.5ml + 5 mcg dexmedetomidine (test solution will diluted with normal saline to total volume of 3.0 ml). **Result:** The mean time for onset of sensory block was 10.59 ±4.06 min in the saline group and 8.31±2.93 min in the dexmedetomidine group and 2.21±1.19 min in the fentanyl group. The mean time taken to achieve maximum sensory block in group A was 15.62±4.91 min, in group D was 13.18±3.51 min and in group F it was 5.28±1.92 min so maximum sensory block was achieved earlier in group. Peak level of sensory block attained in the fentanyl group was T4 and the peak level of sensory block in dexmedetomidine group was T6 and in the saline group peak level was T8. So the highest sensory block was attained in the fentanyl group. The mean duration of sensory block in group A was 113.47±7.12min, and in group F was 161.11±12.74min., and in group D was 204.12±6.41 min. Prolong duration occur in the dexmedetomidine group. The prolongation of effect may result from synergism between local anaesthetic and alpha2 adrenoceptor agonist action. The mean onset time of motor block in group A was 11.04±3.98 min, in group D it was 8.97±3.31 min, in group F it was 3.31 ±1.33 min. Onset of motor block occurred earlier in the fentanyl group. In the present study there was a significant difference in duration of motor block across the three groups with p value <0.001. In group A mean duration of motor block was 161.04±6.30 min, and in group D was 253.26±6.59 min and in group F it was 186.74±11.64 min. **Conclusion:** Dexmedetomidine group has longer onset of and duration of sensory block and effective postoperative analgesia and fewer side effect as compared to fentanyl group.

**Keywords:** Subarachnoid block, Levobupivacaine, anesthesia.

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### Introduction

Lower limb surgeries could be performed under local, neuroaxial and general anesthesia, but neuroaxial block is the preferred method. Spinal block has rapid onset, deep block, lower risk of infection and is cost effective. However, post-operative pain is an important problem as the used drugs have limited duration of effect; so the post-operative analgesic administration is necessary[1,2]. Administering the combinations of other classes of analgesics with local anesthetics has used to increase the duration and reduce side effects of analgesia[3]. Some drugs have been used as adjuvants in spinal anesthesia to prolong intraoperative and postoperative analgesia[1,2] including opioids,  $\alpha_2$  agonists, neostigmine, vasoconstrictors, etc. Clonidine and dexmedetomidine are two  $\alpha_2$

agonists affecting via pre- and post-synaptic  $\alpha_2$  receptors [4]. Dexmedetomidine has been widely used for anesthesia and analgesic purposes. This drug has sedative, anti-anxiety, analgesic, neuroprotective, and anesthetic-sparing effects [5]. Dexmedetomidine along with other drugs have been used to increase the duration of analgesia in subarachnoid, epidural and caudal blocks[6,7]. Levobupivacaine causes less cardiovascular and neurological events. Onset of sensory and motor block is hastened with Hyperbaric Levobupivacaine compared to Isobaric Levobupivacaine. Increased protein binding and higher clearance explains cardiostability of Levobupivacaine[8]. Fentanyl is a synthetic opioid with central action, which is used widely for pain control. Intrathecal fentanyl is usually added to other local anesthetics to increase anesthesia and analgesia. It has improved spinal anesthesia and reduced the anesthetic drug related side effects including pruritus, nausea and vomiting[9]. Dexmedetomidine and fentanyl have been used as adjuvant to local anesthetics in different surgeries to provide superior analgesia and to improve the duration of the block[10-12]. In this study we propose to compare a combination of isobaric

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Levobupivacaine with fentanyl and dexmedetomidine for the characteristics of spinal blockade with respect to onset, duration and hemodynamic parameters and side effect.

#### Material and methods

This was a prospective, randomized, and double blinded clinical comparative study conducted in the Department of Anaesthesiology, Jawaharlal Nehru medical college and hospital Bhagalpur, Bihar, India from March 2019 to February 2020, after taking the approval of the protocol review committee and institutional ethics committee.

#### Methodology

We evaluate the effect, hemodynamic stability and adverse effects of using intrathecal dexmedetomidine and fentanyl as an adjuvant to Isobaric Levobupivacaine for lower limb orthopaedic surgery. The study participants were randomly divided into three groups.

The study population consisted of 150 adult patients who were classified as American Society of Anesthesiologists (ASA) physical status I or II, undergoing elective lower limb orthopaedic surgery under spinal anesthesia. 150 patients with age between 20 to 55 yrs of either sex, ASA 1 and 2 and Patient posted for elective lower limb orthopaedic surgeries were include in this study. Patients who had History of allergy to study drugs and Patients using alpha 2-adrenergic receptors antagonists, calcium channel blockers, angiotensin-converting enzyme inhibitor were exclude from the study.

All patients were preloaded with Ringer lactate solution 10ml/kg over 15 minutes before the spinal anaesthesia. The base line heart rates, systolic, diastolic and mean Blood pressure, SpO2 respiratory rate, were recorded. Then after Subarachnoid Block, all the parameters like pulse rate, systolic blood pressure, diastolic blood pressure, mean arterial pressure, SPO2, respiratory rate, level of sensory block, grade of motor block, sedation scale at every 1 minute for 5 minutes; then every 5 minutes till 30 minutes and then every 15 min up to 2 hrs and then after every 30 min till the end of surgery. In the postoperative period following parameters are observed pulse, systolic blood pressure, diastolic blood pressure, mean arterial pressure, SPO2, VAS, 1st rescue analgesic requirement, total analgesic requirement in 24 hr period, sedation scale and side effect were recorded immediately in postoperative recovery room, 0.5 hr, 1 hr, 1.5 hr, 2 hr, 3 hr, 4 hr, 8 hr, 12 hr, 18 hr, 24 hr period.

- Group A: 0.5% Levobupivacaine Isobaric 2.5ml+ 0.5ml normal saline (total volume is upto 3.0 ml).
- Group F: 0.5% Levobupivacaine Isobaric 2.5ml + 25mug fentanyl (test solution will diluted with normal saline to total volume of 3.0ml).

- Group D: 0.5% Levobupivacaine isobaric 2.5ml +5 mcg dexmedetomidine (test solution will diluted with normal saline to total volume of 3.0 ml).

Sensory anesthesia assessed by loss of sharp sensation to pinprick test in the midclavicular line. Motor blockade was determined using Modified Bromage scale.

#### Result

The mean time for onset of sensory block was 10.59 ±4.06 min in the saline group and 8.31±2.93 min in the dexmedetomidinegroup and 2.21±1.19 min in the fentanyl group. The mean time taken to achieve maximum sensory block in group A was 15.62±4.91 min, in group D was 13.18±3.51 min and in group F it was 5.28±1.92 min so maximum sensory block was achieved earlier in group. Peak level of sensory block attained in the fentanyl group was T4 and the peak level of sensory block in dexmedetomidine group was T6 and in the saline group peak level was T8. So the highest sensory block was attained in the fentanyl group. The mean duration of sensory block in group A was 113.47±7.12min, and in group F was 161.11±12.74min., and in group D was 204.12±6.41 min. Prolong duration occur in the dexmedetomidine group. The prolongation of effect may result from synergism between local anaesthetic and alpha2 adrenoceptor agonist action. The mean onset time of motor block in group A was 11.04±3.98 min, in group D it was 8.97±3.31 min, in group F it was 3.31 ±1.33 min. Onset of motor block occurred earlier in the fentanyl group. In the present study there was a significant difference in duration of motor block across the three groups with p value <0.001. In group A mean duration of motor block was 161.04±6.30 min, and in group D was 253.26±6.59 min and in group F it was 186.74±11.64 min. There was a significant difference in the pulse rate, systolic blood pressure, diastolic blood pressure and mean arterial blood pressure from the 2 min to 20 min in the intraoperative period. In the postoperative time period the pulse rate, systolic blood pressure, diastolic blood pressure, mean blood pressure was not statistically significant with p value of >0.05. In regard, first analgesic requirement was prolonged in group D as compared to group A and group F and requirement of 24 hr analgesia was also found lower in the dexmedetomidine group, and however supplementary analgesia in the form of diclofenac 75 mg iv was required in group A only. No patient in any of the groups had side effects like shivering, pruritus, nausea vomiting and no patient had episode of respiratory depression. There was 30 (60%) patient in the dexmedetomidine group had bradycardia while in the fentanyl group 4(8%) patients and in the saline group 2 (4%) patients had bradycardia being statistically significant.

Table 1: Comparison of demographic parameters

Parameters	Group A	Group D	Group F	P-value
	(n=50)	(n=50)	(n=50)	
Age (years) [mean±SD]	36.15±9.78	37.67±14.98	38.87±14.48	0.598 (NS)†
Gender [No. (%)]				
Male	35 (70)	39 (78)	34 (68)	0.548(NS)*
Female	15 (30)	11 (22)	16(32)	
ASA				
1	48 (96)	46 (92)	46 (92)	0.669 (NS)*
2	2 (4)	4 (8)	4 (8)	
weight (mean ±SD)	63.29±2.69	63.32±1.74	63.98±2.12	0.423 (NS)
Height (mean ±SD)	159.12±2.61	159.81±2.84	159.19±3.18	0.574 (NS)
duration of surgery (mean ±SD)	90.87±16.74	97.18±18.36	99.49±13.13	0.052 (NS)

\*Obtained using ANOVA; S: Significant; NS: Not Significant; †First significant drop compared to baseline

Table 2: Comparison of Sensory and Motor block parameters across three groups

Parameters	Mean ± SD						P-value
	Group A		Group D		Group F		
	(n=50)	(n=50)	(n=50)	(n=50)	(n=50)	(n=50)	
Onset of sensory block (in min)	10.59	4.06	8.31	2.93	2.21	1.19	< 0.001* (S)

Duration of sensory block (in min)	113.47	7.12	204.12	6.41	161.11	12.74	< 0.001* (S)
Onset of motor block (in min)	11.04	3.98	8.97	3.31	3.31	1.33	< 0.001* (S)
Duration of motor block (in min)	161.04	6.41	253.26	6.59	186.74	11.64	< 0.001* (S)
Time taken to achieve for maximum sensory block (in min)	15.62	4.91	13.18	3.51	5.28	1.92	< 0.001* (S)
Bromage Scale	[No. (%)]						
3: Inability to raise leg, flex knee or ankle or move toes	50	100	50	100	50	100	< 0.001† (S)

\*Obtained using ANOVA; † Obtained using Chi-square test; S: Significant

**Table 3: Comparison of maximum sensory block attained in three groups**

Maximum sensory block attained	Group A (n=50)	Group D (n=50)	Group F (n=50)	P-value*
T4 dense	0	0	3 (6)	< 0.001 (S)
T6 dense	0	7 (14)	35 (70)	
T8 dense	7 (14)	26 (52)	12 (24)	
T10 dense	43 (86)	17 (34)	0	

\*Obtained using Chi square test; S: Significant

**Table 4: Frequency distribution according to first analgesic requirement in patients – Post operative period**

Post-operative first analgesic requirement	No. (%)
Group A	
Intraoperative	21(42)
Postoperative recovery	14(28)
0.5hr	15 (30)
Group D	
2 hr	2(4)
3 hr	10 (20)
4 hr	25 (50)
6 hr	13 (26)
Group F	
Postoperative recovery room	6(12)
0.5 hr	24(48)
1 hr	16 (32)
2 hr	4 (8)

**Table 5: Frequency distribution according to total analgesic requirement in 24 hr – Postoperative period**

Group / Number of doses in 24 hr.	No. (%)
Group A	
4	18 (36)
5	26 (52)
6	6 (12)
Group D	
1	3 (6)
2	46 (92)
3	1 (2)
Group F	
1	2 (4)
2	9 (18)
3	39 (78)

## Discussion

In this study we compared the 5 mcg dose of dexmedetomidine with 25 mcg dose of fentanyl administered to the Isobaric Levobupivacaine. There were very few studies that compared both the doses simultaneously with Isobaric Levobupivacaine; we have compared and discussed our results with various other studies using similar adjuvants in same doses but in combination with various local anaesthetic as well in various surgeries. The values of the demographic variables were comparable between the three groups. Onset of sensory block defined as time taken to attain the T12 dermatomal level. Our study showed mean time for onset of sensory block was  $10.59 \pm 4.06$  min in the saline group and  $8.31 \pm 2.93$  min in the dexmedetomidine group and  $2.21 \pm 1.19$  min in the fentanyl group. So onset of sensory block occurred earlier in the fentanyl group

Mohamad Kamal et al in 2017[13] found that the onset of sensory block was  $3.22 \pm 0.69$  min in the group F and  $3.90 \pm 0.94$  min in the group D with p value highly significant  $p < 0.001$ . Shelly Rana[14] in 2017 stated that the earlier onset with fentanyl can be attributed to its lipophilic properties. The lipophilic opioids rapidly traverse the dura mater, where they are sequestered in the epidural fat and enter the systemic circulation; they also rapidly penetrate the spinal cord where they binds opioid receptors within the white matter as well as dorsal horn receptors and eventually enter the systemic circulation as they are cleared from the spinal cord. Al Ghanem et al 2009[15] found the onset time for sensory block was upto T10 level and it was  $7.5 \pm 7.4$  min in dexmedetomidine group and  $7.4 \pm 3.3$  min in fentanyl. The mean time taken to achieve maximum sensory block in group A was  $15.62 \pm 4.91$  min, in group D was  $13.18 \pm 3.51$  min and in group F

it was  $5.28 \pm 1.92$  min so maximum sensory block was achieved earlier in group F. Nayagam HA et al.[16] found that the mean time for peak sensory levels was  $(11.88 \pm 2.156)$  min in fentanyl group and in dexmedetomidine group it was  $(12.92 \pm 3.131)$  min. The difference between the two means was statistically significant. ( $p < 0.05$ ). Al Ghanem et al in 2009[15] studied and found that time to reach the maximum sensory block was around  $19.34 \pm 2.87$  min in the dexmedetomidine group and  $18.39 \pm 2.46$  min in the fentanyl group which was statistically insignificant with p value of 0.12.

Peak level of sensory block attained in the fentanyl group was T4 and the peak level of sensory block in dexmedetomidine group was T6 and in the saline group peak level was T8. So the highest sensory block was attained in the fentanyl group. Ghanem M Subhi et al.<sup>15</sup> (2009) found out that highest sensory level was T6 in the Dexmedetomidine group and in the fentanyl group it was around T8 level. Mean duration of sensory block in group A was  $113.47 \pm 7.12$  min, and in group F was  $161.11 \pm 12.74$  min., and in group D was  $204.12 \pm 6.41$  min. Prolong duration occur in the dexmedetomidine group. The prolongation of effect may result from synergism between local anaesthetic and alpha2 adrenoceptor agonist action. Ahmed Basuni et al.[17] in 2013 also stated the prolongation of the block in the dexmedetomidine.

In our study mean onset time of motor block in group A was  $11.04 \pm 3.98$  min, in group D it was  $8.97 \pm 3.31$  min, in group F it was  $3.31 \pm 1.33$  min. Onset of motor block occurred earlier in the fentanyl group. Mohamad Kamal et al.[13] found that onset of motor block was  $3.74 \pm 0.57$  min in the group F and  $4.44 \pm 0.91$  min in the group D with p value  $< 0.001$ . In the present study there was a significant difference in duration of motor block across the three groups with p value  $< 0.001$ . In group A mean duration of motor block was  $161.04 \pm 6.30$  min, and in group D was  $253.26 \pm 6.59$  min and in group F it was  $186.74 \pm 11.64$  min. Mahendru et al.[18] found that duration of motor block was  $(161.5 \pm 19.8)$  min in saline group.  $(196.0 \pm 26.8)$  min in group fentanyl and  $(198.7 \pm 26.4)$  min in clonidine,  $(273.3 \pm 24.6)$  min in the dexmedetomidine group ( $P < 0.0001$ ). Rayees Ahmad et al.<sup>19</sup> found duration of motor block in the fentanyl group was around  $152.90 \pm 8.31$  min and in the dexmedetomidine group it was around  $419.70 \pm 16.85$  min ( $p < 0.001$ ).

In the present study there was a significant difference in the pulse rate, systolic blood pressure, diastolic blood pressure and mean arterial blood pressure from the 2 min to 20 min in the intraoperative period. In the postoperative time period the pulse rate, systolic blood pressure, diastolic blood pressure, mean blood pressure was not statistically significant with p value of  $> 0.05$ . Khan A L et al.<sup>20</sup> inferred that the heart rate at all intervals was lower in dexmedetomidine group when compared to fentanyl group. Rao et al.<sup>21</sup> found that the significant decrease in the pulse rate was observed in the dexmedetomidine group as compared to the fentanyl and control. Ahmed Basuni et al.[17] found that blood pressure was comparable in the two groups throughout the surgery. 2 patients in group F showed intraoperative period hypotension. Mohamad Kamal et al.[13] stated that hypotension occur in both the groups but the value was not statistically significant in using the intravenous vasopressor therapy.

Mechanism of sedation in the dexmedetomidine group is due to action on the sleep promoting pathway. In the present study both intraoperative and postoperative period dexmedetomidine contribute to sedation scale 2. Rajani Gupta R et al.[22] stated that the mean sedation score was  $(3.8 \pm 0.5)$  in group dexmedetomidine as compared to  $(2.2 \pm 0.53)$  in group fentanyl ( $P < 0.05$ ). Rayees Ahmad R et al.[19] found the mean sedation score for group dexmedetomidine was  $(3.40 \pm 0.49)$  and in fentanyl was  $(2.16 \pm 0.37)$ , ( $P < 0.001$ ). There was no significant difference between the three groups in the respiratory rate. Similar to Ahmed Sobhy Basuni et al.<sup>17</sup> and R. Ahmed et al.[19] In regard, first analgesic requirement was prolonged in group D as compared to group A and group F and requirement of 24 hr analgesia was also found lower in the dexmedetomidine group, and however

supplementary analgesia in the form of diclofenac 75 mg iv was required in group A only.

Aamir Laique Khan et al.[20] studied that the time for first analgesic requirement in the dexmedetomidine group was  $(280 \pm 7.84)$  min and in the fentanyl group it was  $(173.88 \pm 8.12)$  min after the starting of surgery which was highly significant with p value of ( $< 0.001$ ).

Farhad Safari et al.[23] Total morphine doses in 24 hours was significantly lower in the dexmedetomidine group as compared to fentanyl and control groups ( $P < 0.05$ ).

Ayman Eskander et al.[24] found that the postoperative analgesic requirement in first 24 hr was significantly lower in the dexmedetomidine and the fentanyl group compared to the control group and it was significantly lower in the dexmedetomidine group than fentanyl group ( $p < 0.05$ ).

In the present study no patient had episode of respiratory depression. Vidhi Mahendru et al.[18] Rajani Gupta et al.[22] in both the studies there was no evidence of respiratory depression. In the present study no patient in any of the groups had side effects like shivering, pruritus, nausea vomiting, similar to Ahmed Basuni et al.[17], Al Ghanem et al.[15] stated that that 2 (5%) patients in the dexmedetomidine group and 4(10%) patients in the Fentanyl group had nausea and vomiting with p value of 0.401, no patient in the dexmedetomidine group got pruritus and 5 patients in the fentanyl group had pruritus.

Gupta R et al.[22] studied intrathecally dexmedetomidine and fentanyl as adjuvant to Bupivacaine in lower abdominal surgeries. In group dexmedetomidine only one patient had Nausea and no patient had vomiting while in group fentanyl two patients had nausea and one patient had vomiting. One patient in the fentanyl group had pruritus. In the present study 30 (60%) patient in the dexmedetomidine group had bradycardia while in the fentanyl group 4(8%) patients and in the saline group 2 (4%) patients had bradycardia being statistically significant. However there was no episode of bradycardia found in Ahmed Sobhy Basuni et al.[17] in 2013 and Mohamad Kamal et al.[13] studies. Ghanem et al.[15] stated that side effect of bradycardia was less because small dose of intrathecal dexmedetomidine was used in their study.

In our study, 37 patients in the fentanyl group had episode of hypotension. Which was treated with injmephentermine 3 mg in incremental doses. The maximum hypotension occur in the F Ahmad R et al.[19] studied they found that 14(28.0%) patients in group fentanyl and 8 (16.0%) patients in group dexmedetomidine had hypotension.

#### Conclusion

Dexmedetomidine group has longer onset of and duration of sensory block and effective postoperative analgesia and fewer side effect as compared to fentanyl group.

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