



European Society of  
Regional Anaesthesia  
& Pain Therapy

**ESRA ITALIA**

**ESRA** *Cè*

# XXIX

## CONGRESSO NAZIONALE

ESRA Italian Chapter  
CESENA, Cesena fiere

Presidente del congresso  
**Vanni Agnoletti**  
**Domenico Pietro Santonastaso**  
**Andrea Tognù**

7-9  
*Novembre*  
2024



 **MZ**  
EVENTS



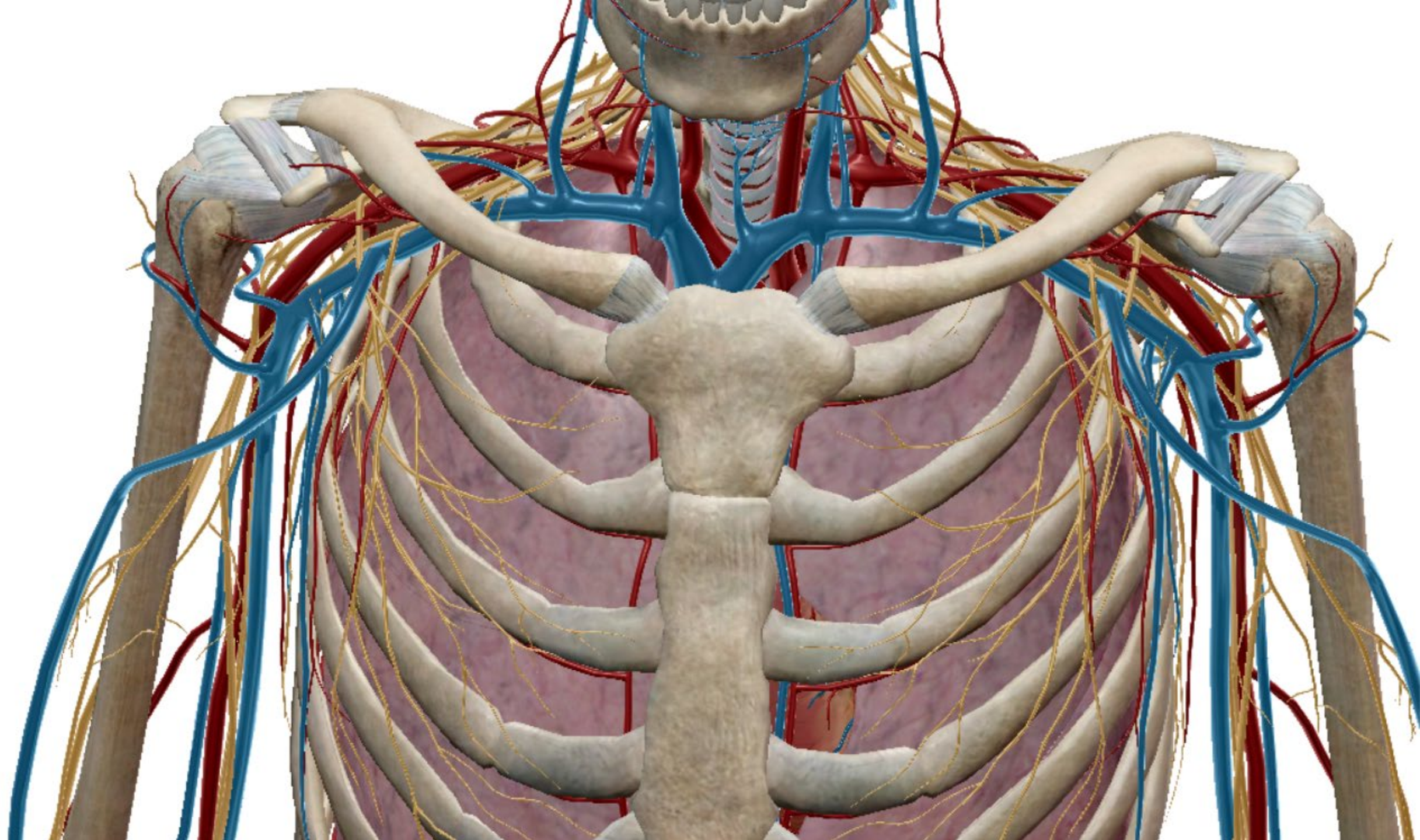
# Studio ecografico delle vene dell'arto superiore (RaPeVa) e il protocollo SIP-2 per il posizionamento ecoguidato di PICC.

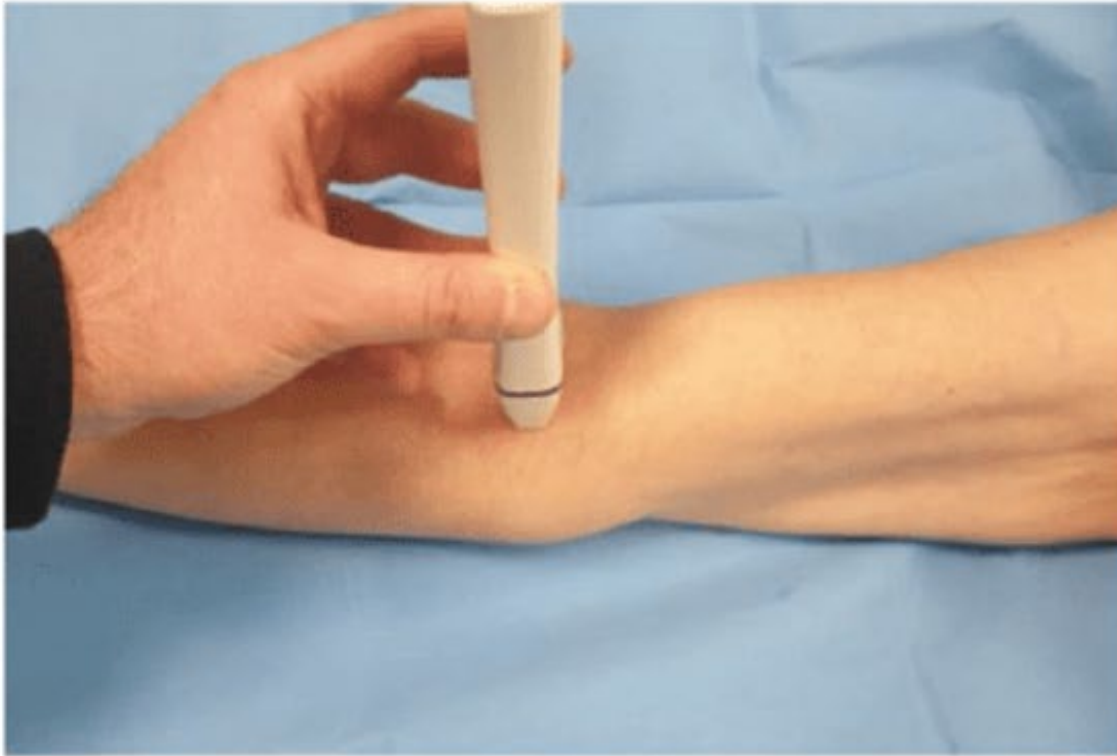
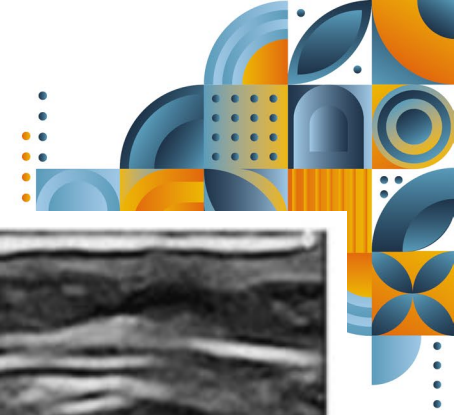
Vittorio Cerotto

Anestesia Rianimazione e Terapia del Dolore

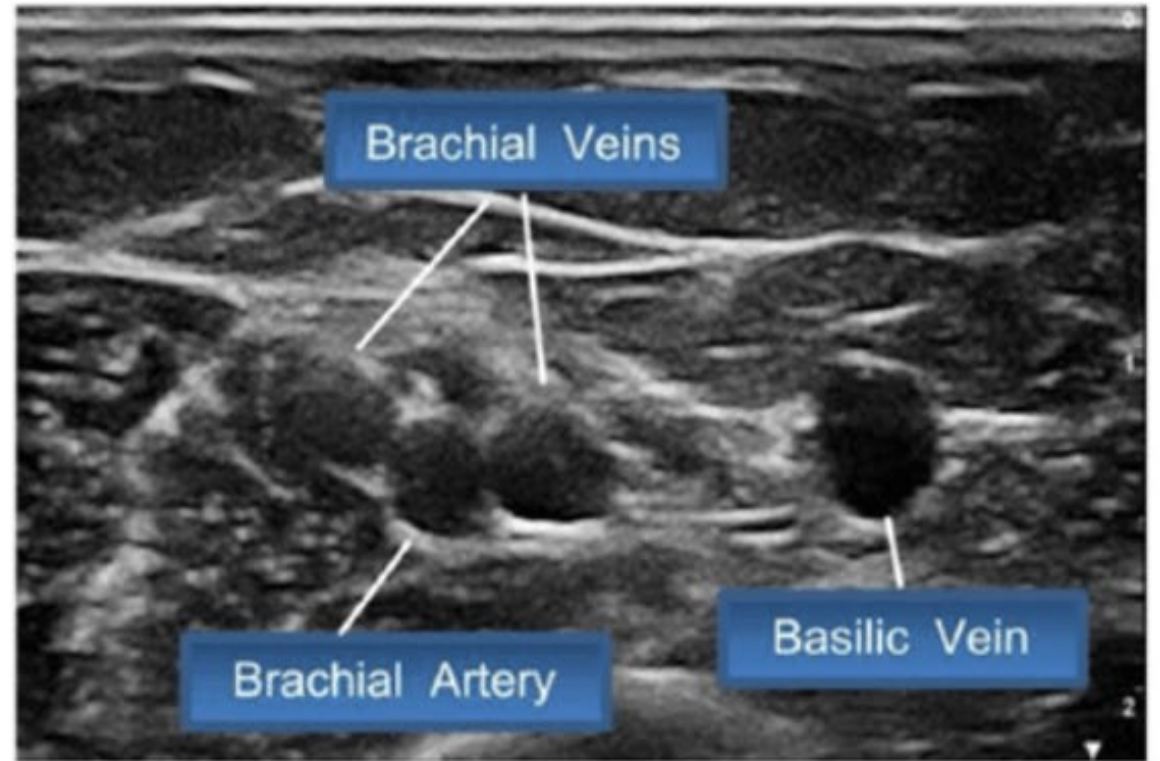
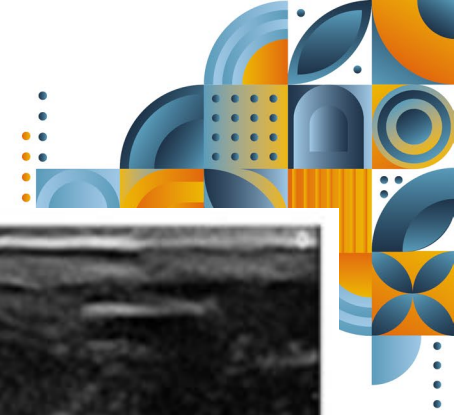
USL Umbria 1

[vittorio.cerotto@uslumbria1.it](mailto:vittorio.cerotto@uslumbria1.it)

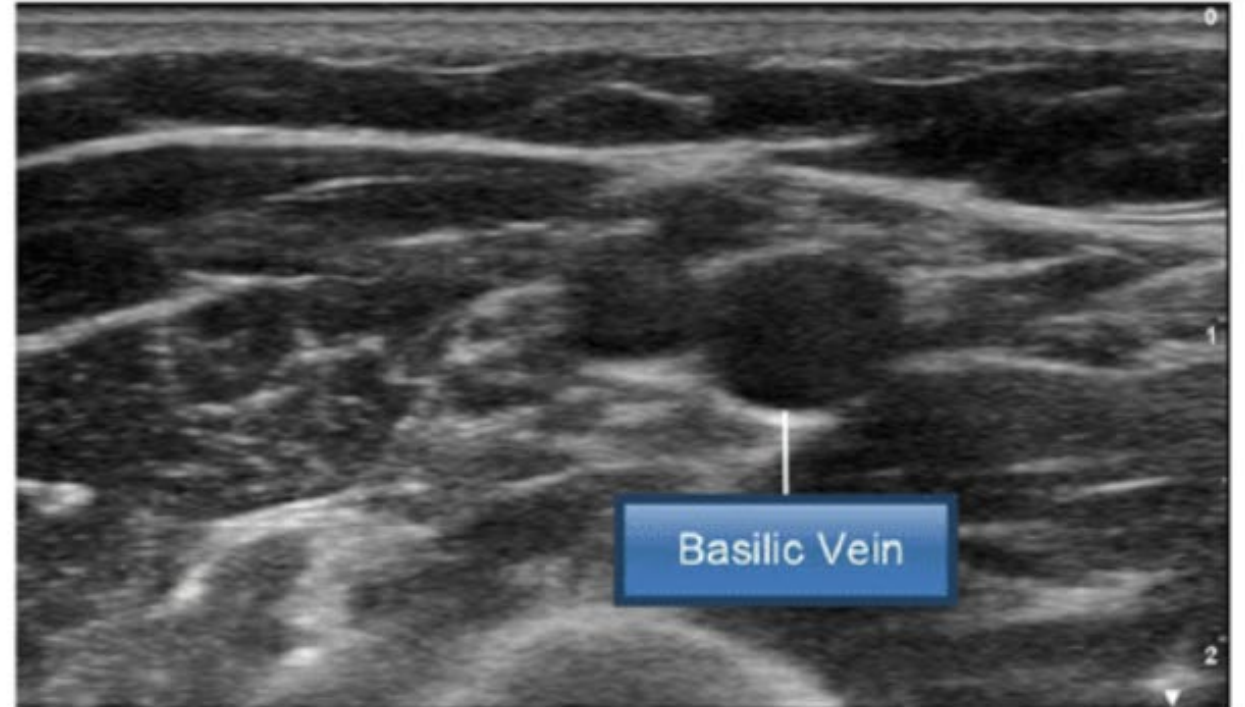
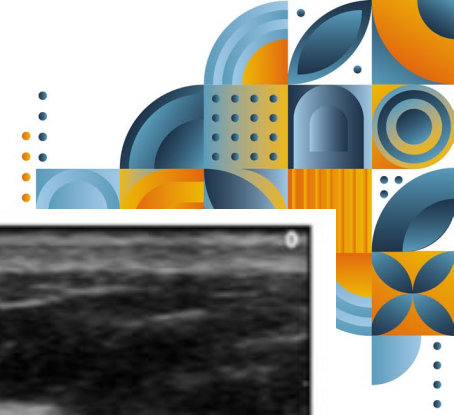




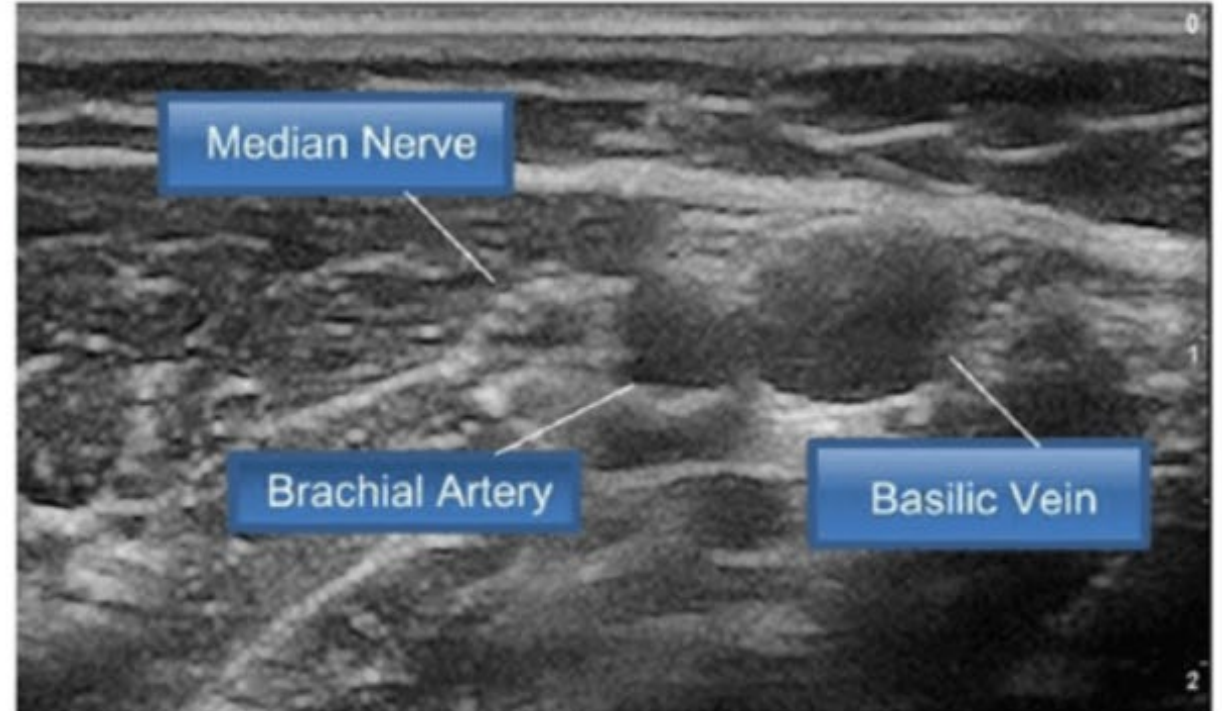
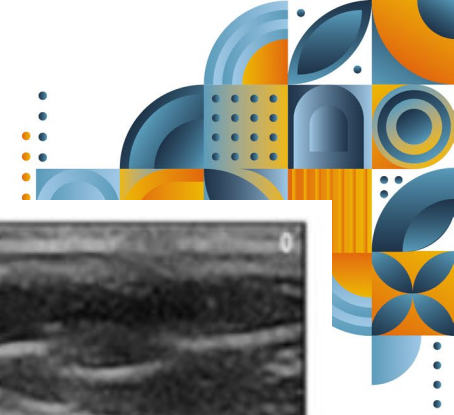
**Vena cefalica in fossa antecubitale**



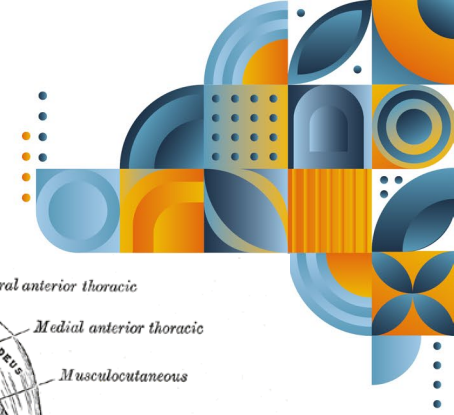
**Arteria e vene brachiali e confluenza  
della vena antecubitale nella basilica**



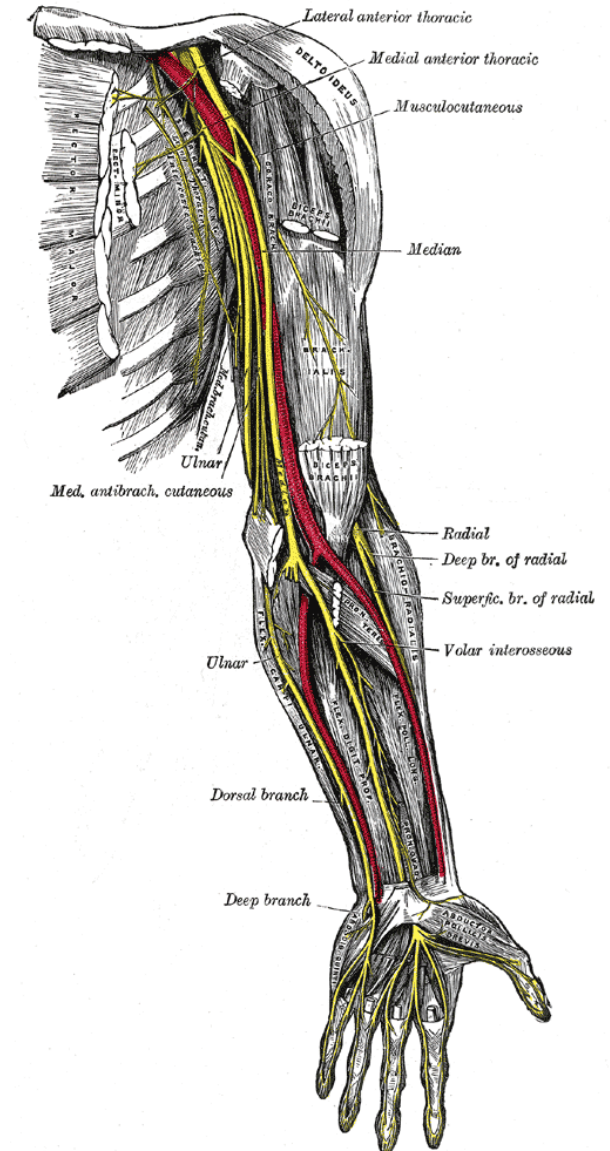
**Vena basilica nel solco bicipito-omeroale**



# Fascio vascolo-nervoso

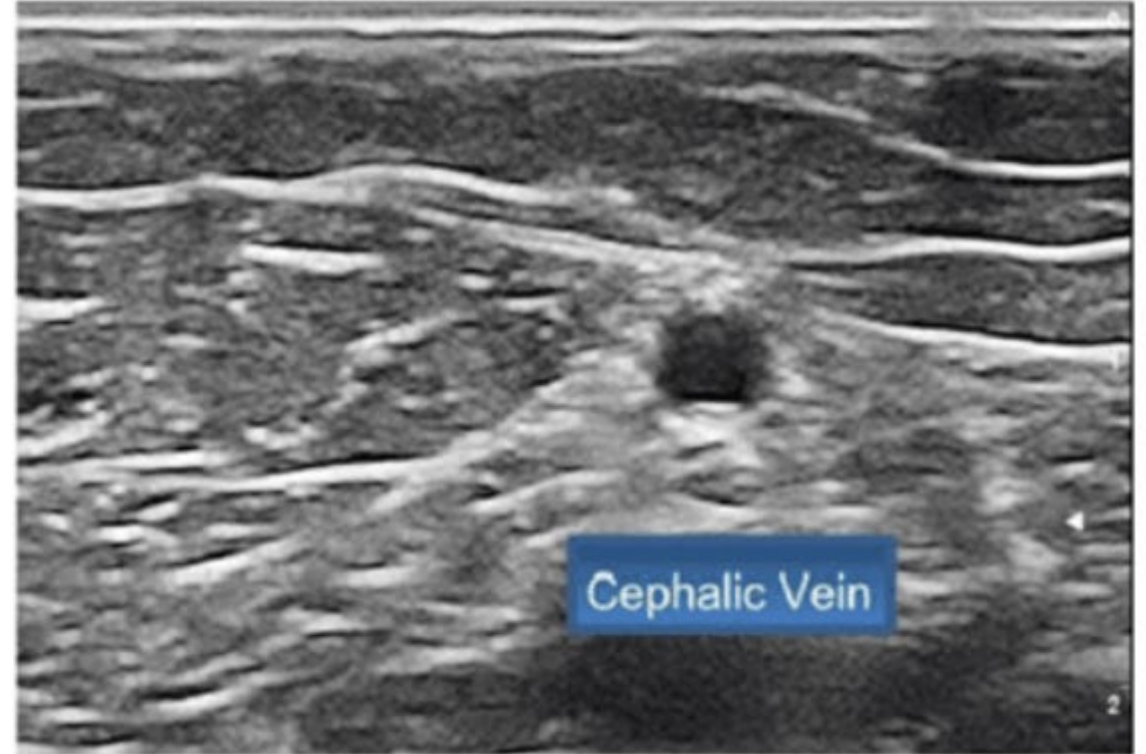
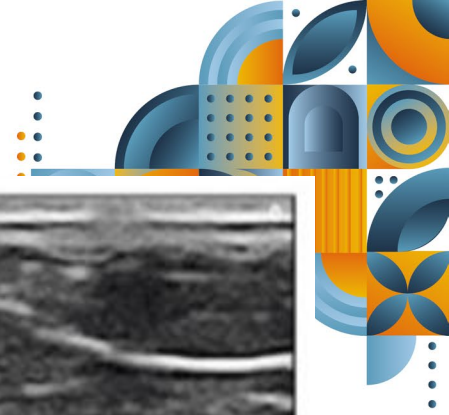


- Spesso visibile tra vena ed arteria brachiale in posizione variabile
- La traiettoria dell'ago deve EVITARE il nervo mediano
- Percorre la loggia anteriore del braccio, davanti al setto intermuscolare mediale e lateralmente all'arteria brachiale. Costeggia prima il muscolo coracobrachiale e poi il margine mediale del bicipite. A livello variabile durante il suo decorso nel braccio scavalca l'arteria e pertanto vi si pone medialmente. Giunto a questa altezza dà un ramo per l'articolazione del gomito.

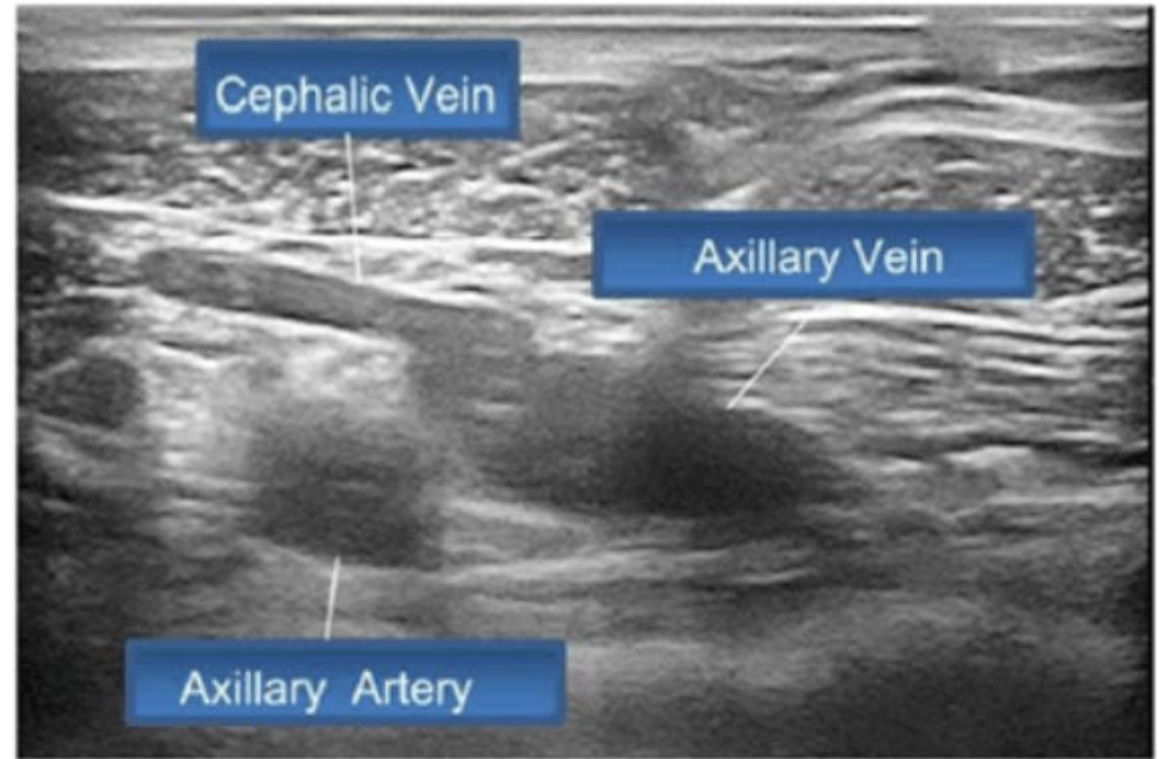
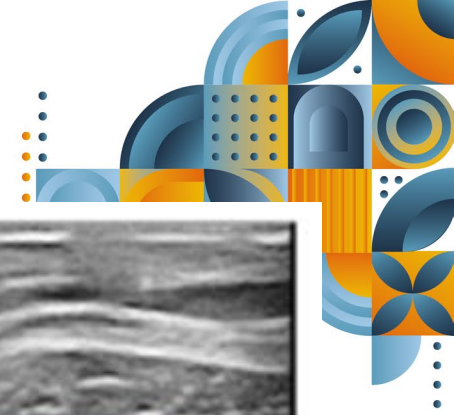


# NERVO MEDIANO



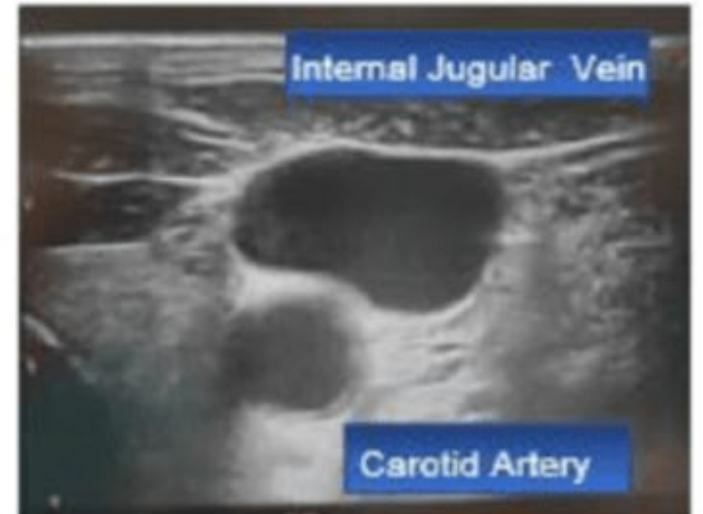
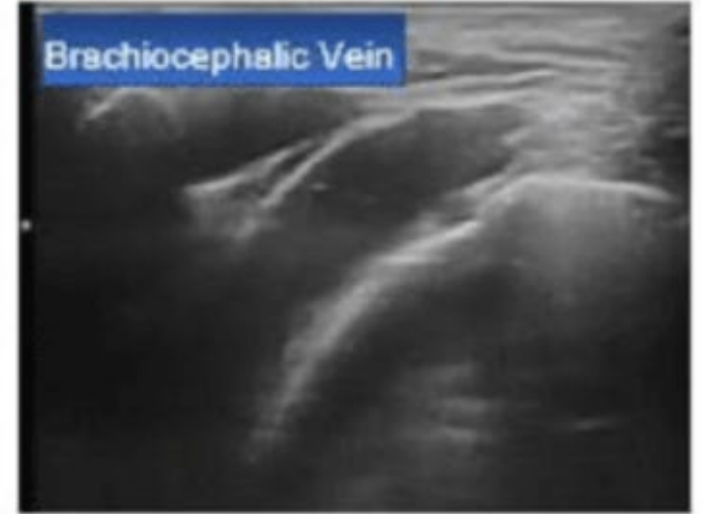


# Cefalica bicipite



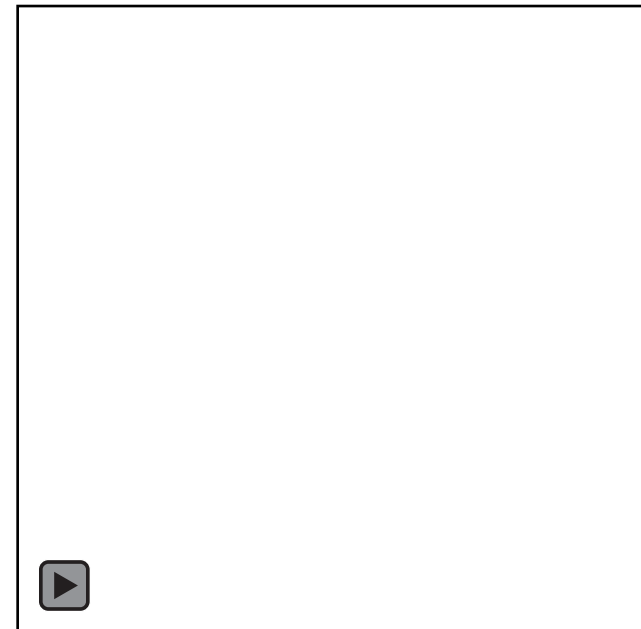
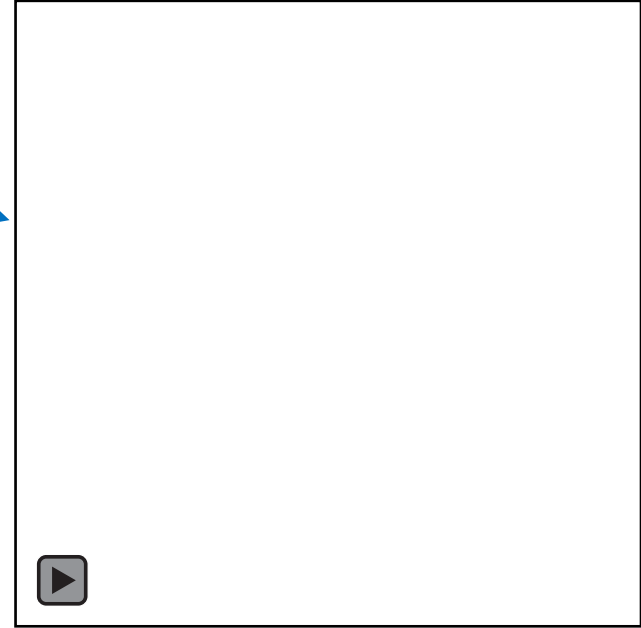
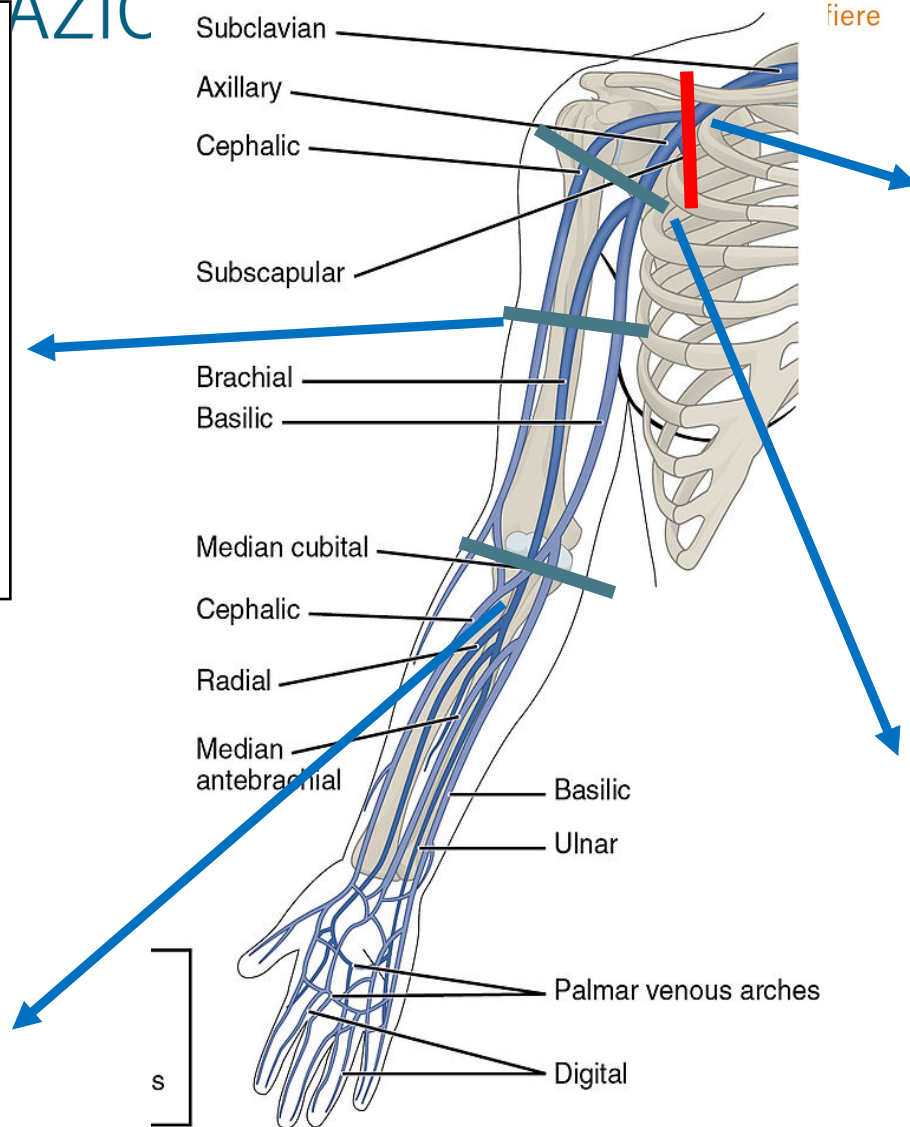
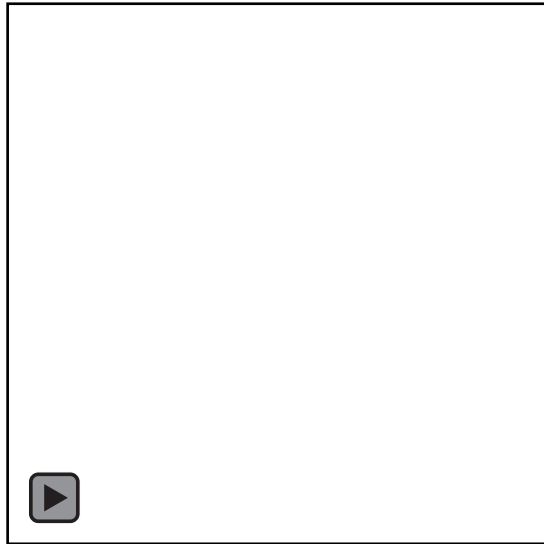
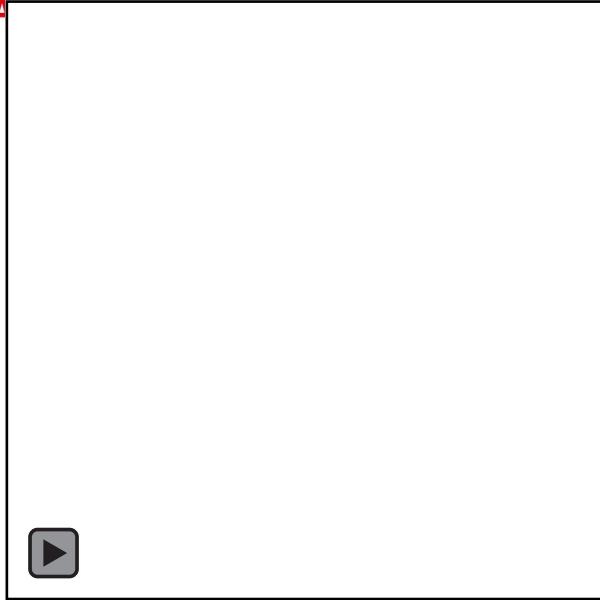
# Vena ascellare infraclaveare

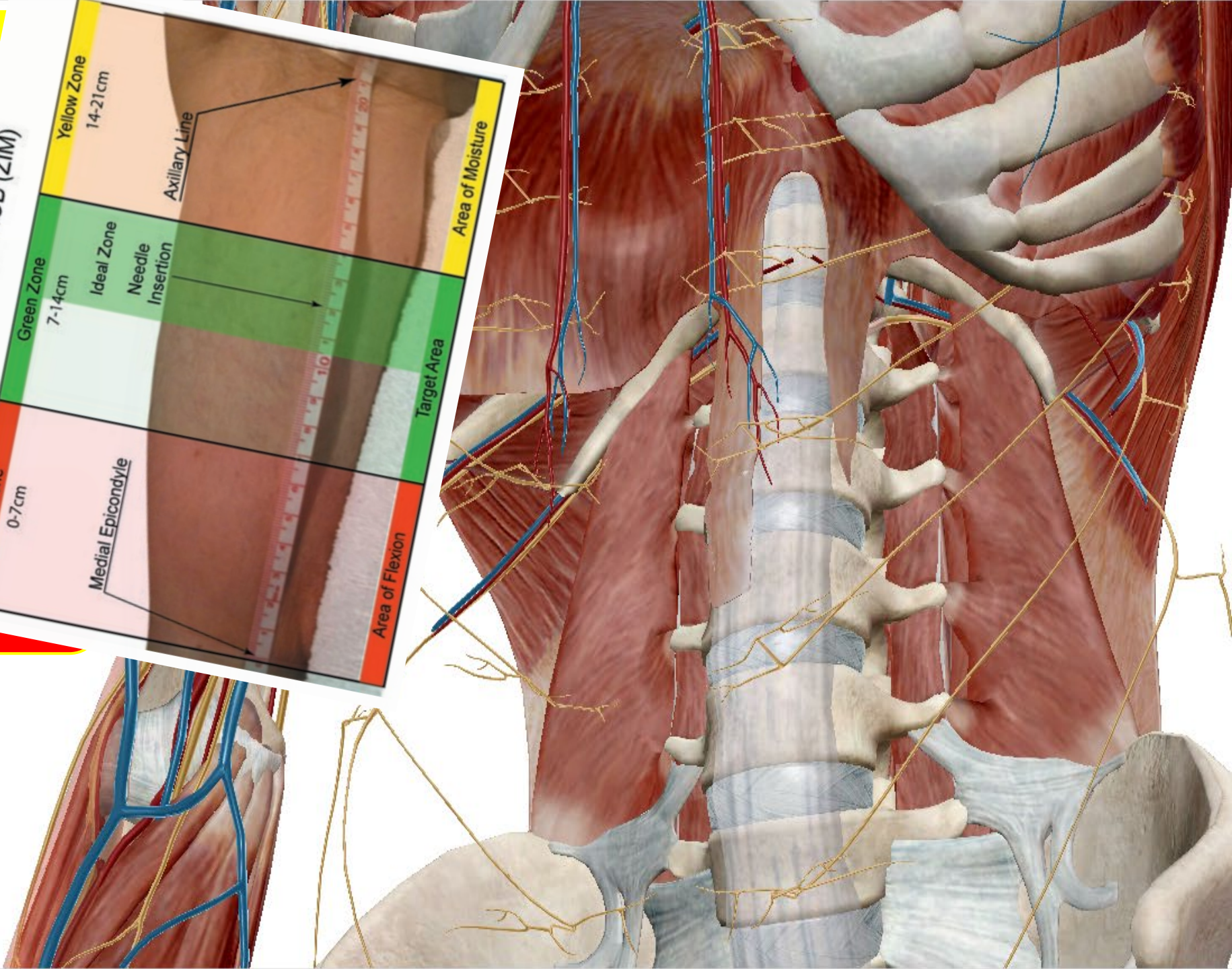
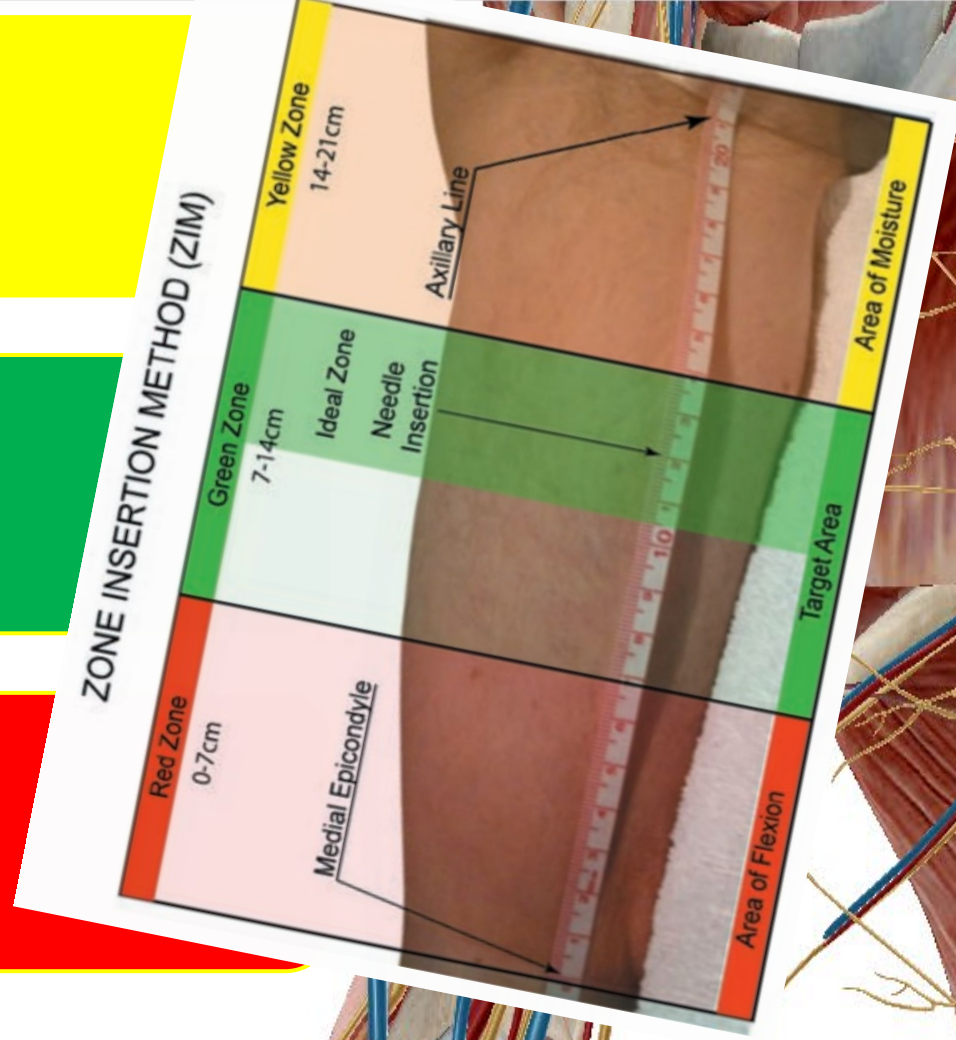
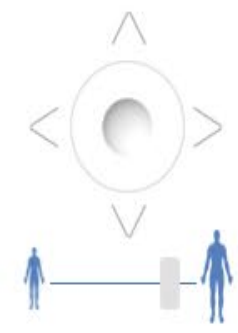
**Giugulare interna, succlavia, brachiocefalica**

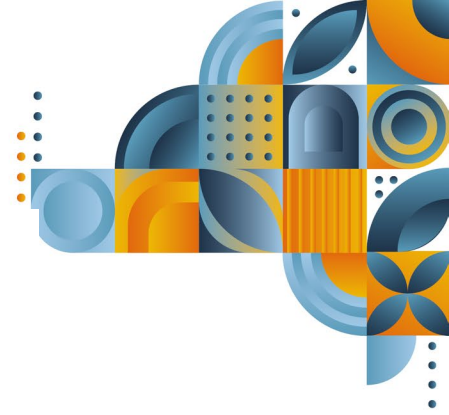




# Arto superiore







## The SIP protocol update: Eight strategies, incorporating Rapid Peripheral Vein Assessment (RaPeVA), to minimize complications associated with peripherally inserted central catheter insertion

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Step 1	<i>Pre-procedural evaluation</i> —choose most appropriate vein by systematic ultrasound examination of the veins of the arms (see the RaPeVA protocol)
Step 2	<i>Appropriate antiseptic technique</i> —adopt a strict policy of hand hygiene, skin antiseptics with 2% chlorhexidine in 70% isopropyl alcohol, and use of maximal barrier precautions
Step 3	<i>Choice of vein size and exit site</i> —evaluate the diameter of the vein so to have an ideal catheter-vein ratio (1:3 or less); place the exit site in the green zone (see Dawson’s ZIM™); consider the opportunity of tunneling the catheter, if the most appropriate vein is in the yellow zone (see the RAVESTO protocol)
Step 4	<i>Clear identification of median nerve and brachial artery</i> —identify each structure before venipuncture, using ultrasound
Step 5	<i>Ultrasound-guided venipuncture</i> —access a deep vein of the arm (either basilic or brachial vein), preferably adopting the short axis/out-of-plane approach, and use of a micro-introducer kit
Step 6	<i>Ultrasound-based tip navigation</i> —assess the correct direction of the guidewire, by a supra-clavicular ultrasound scan (see the ECHOTIP protocol)
Step 7	<i>Intra-procedural assessment of tip location</i> —use intracavitary ECG and/or ultrasound (subcostal or apical view, using the “bubble test”: see the ECHOTIP protocol)
Step 8	<i>Appropriate securement of the catheter and protection of the exit site</i> —use sutureless devices only; reduce the risk of bleeding and bacterial contamination using cyanoacrylate glue and semi-permeable transparent membrane dressings

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Grazie