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Original Research Article

Video-assisted pre-anaesthetic patient education in regional anaesthesia: A prospective study on patient anxiety

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Abstract

Background: Patients undergoing regional anaesthesia (RA) commonly suffer from anxiety in the perioperative period. Anxious patients are known to have increased requirements of anaesthetic medications and this has been proven to have deleterious physiological outcomes. This study aimed to evaluate the effects of an educational video related to procedures in RA in reducing preoperative anxiety.

Materials and Methods: The study included 84 patients scheduled for routine elective surgeries under regional anaesthesia. Participants were randomly assigned to two groups: the Video (V) group, which received preoperative video-based education related to the procedure, and the Non-Video (NV) group, which received only a verbal description. Pre- and post-operative anxiety and information scores were assessed using the Amsterdam Preoperative Anxiety and Information Scale (APAIS) for both groups.

Results: Patients who watched the educational video preoperatively experienced a significant reduction in anxiety levels on the day of surgery compared to those who received only a verbal description of the procedure. The video group showed a higher percentage of patients reporting low anxiety (73.8%) on the day of surgery, while the non-video group had only 14.3% reporting low anxiety. Additionally, the video group demonstrated a reduced need for further information, highlighting the effectiveness of multimedia interventions in managing perioperative anxiety.

Conclusion: Procedure-related educational videos effectively reduce perioperative anxiety. Integrating these interventions into anaesthetic practice can alleviate patient stress, enhance patient experience, and reduce miscommunication. Future research should explore their impact on anaesthesia management and recovery outcomes.

Keywords: Educational videos, Perioperative anxiety, Regional anaesthesia, Patient experience, Recovery outcomes.

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1. Introduction

Preoperative anxiety is profound fear experienced by all patients awaiting surgery. This vague and uneasy feeling of discomfort is ubiquitous in patients awaiting surgery with incidence varying from 60–80% in various studies.[1] While pre-operative anxiety includes both fear of surgery and anaesthesia, if left un-addressed it may alter the dynamics of an elective surgical procedure.[2,3] By heightening the body's sympathetic response and altering the physiologic parameters, anxiety is known to increase the requirements of anaesthetic medications especially analgesics. This may negatively affect the patient's perceptions of perioperative care and satisfaction.

Studies show that when compared with general anaesthesia, (GA) peri-operative anxiety is less in patients when procedures are done under Regional anaesthesia (RA).[4] It has been noted that GA may alleviate anxiety in some patients with the prospect of being completely unconscious during surgery. But in some patients, the idea of losing consciousness, concerns with loss of control, fear of potential side-effects can be anxiety inducing.

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Regional anaesthesia involves numbing a part of the body by infiltrating a peripheral nerve with an anaesthetic agent thus blocking its transmission to avoid or relieve pain. It involves remaining awake during the peri-operative period with or without mild sedation. This can be comforting for some, while others may find it unsettling. Discomfort is especially felt during needle insertions or when numbness occurs in the surgical area. Research on public fears and perceptions about RA shows that about one-third of patients were deeply worried about permanent paralysis, back injury, pain, the needle used, and remaining conscious during the procedure. These factors contribute to pre-operative anxiety despite the potential benefits of RA.[5-7] Alleviating preoperative anxiety in patients receiving RA by patient education could therefore, go a long way in improving surgical outcomes by shortening hospital stays and reducing lifestyle disruptions.

A pre-anaesthetic check-up is done to evaluate the possible risks associated with administering anaesthesia and formulate a plan during surgery. It is shown that it allows for a special opportunity to also provide patient education about the anaesthetic and thus reduce anxiety.[8] While methods such as written pamphlets and questionnaires have been used to convey information, not all patients may be adequately educated to read and comprehend the information provided thence.

Use of video -assisted patient education videos in allaying patient anxiety has been effectively tried in the past and are proven to be effective and innovative interventions in the present digital age.[1] This study aimed to analyse the effect of informative videos about regional anaesthetic techniques in reducing peri-operative anxiety.

2. Materials and Methods

The study was conducted at a tertiary care hospital within the Department of Anaesthesia, after obtaining approval from the institutional ethics committee (IST.EC/EC/014/2023 EC/NEW/INST/2022/KA/0174) and obtaining informed consent from all participants. The trial was registered with the Central Trial Registry of India (CTRI/2024/07/070783).

The study period spanned from April 2023 to March 2024 and included 84 adult patients scheduled for elective surgery under regional anaesthesia. The study excluded patients who declined participation, were under 18 years of age, were undergoing emergency surgeries, had preoperative anxiety disorders, were obstetric patients, or faced communication barriers. Additionally, patients who were unable to comprehend the Amsterdam Preoperative Anxiety and Information Scale (APAIS) were excluded from the study.(**Figure 1**)

Based on a study by Rajput et al. which reported a standard deviation of 2.62 for the non-video group and 1.44 for the video group, with a mean difference of -1.5, an effect size of 0.7389, a significance level (α) of 5%, and a power of 90% for a two-sided test, the required sample size was calculated to be 84.[8]

The 84 participants were randomly assigned to two primary groups, each consisting of 42 individuals: the Video (V) group and the Non-Video (NV) group. Randomization was performed using a computer-generated algorithm to minimize selection bias. Each primary group was then subdivided into two subgroups of 21 participants: one group receiving spinal anaesthesia (SA) and the other receiving brachial plexus block (BPB), using a chit method.

The Amsterdam Preoperative Anxiety and Information Scale (APAIS) was used to assess anxiety and the need for information regarding anaesthesia and surgery.[9] The scale was translated into regional languages (Kannada, Malayalam, and Hindi) to facilitate comprehension, and validated for the study. The APAIS consists of six questions, divided into two categories: anxiety (questions 1, 2, 4, and 5) and need for information (questions 3 and 6). Each question is rated on a scale from 1 (Not at all) to 5 (Extremely).(**Table 1**)

Table 1: APAIS questionnaire

APAIS Questions	1	2	3	4	5
I am worried about the anaesthesia					
The anaesthetic is on my mind continually.					
I would like to know as much as possible about anaesthetic.					
I am worried about the surgical procedure					
The surgical procedure is on my mind continually					
I would like to know as much as possible about the surgical procedure					

1. Not at all 2. Somewhat 3. Moderate 4. Moderately high 5. Extremely

The anxiety levels of all participants were assessed at two points: initially during the pre-anaesthesia consultation (PAC) before viewing the video or receiving verbal explanation, and again on the day of surgery before transfer to the operating theatre. Both assessments were conducted by the same assessor.

In the V group, patients watched pre-recorded videos detailing the regional anaesthesia procedure (SA or BPB) relevant to their subgroup. The video viewing occurred after the initial baseline APAIS scores assessment.

2.1. Pre-anaesthetic videos

The pre-anaesthesia educational videos were recorded in MP4 format and shown to individual patients with

background narration in their preferred language- English/Hindi/Malayalam/Kannada

Video 1 (SA): A 1 minute 40 second video that describes the procedure for spinal anaesthesia, including ASA monitor attachment, IV cannula placement, patient positioning, and sensory and motor blockade from the umbilicus to the feet. Link to Video 1 (https://drive.google.com/file/d/1FQjSnW8yWZzrBPF6wDTCJxSNvfnBx-FO/view?usp=drivesdk)

Video 2 (BPB): A 2 minute 10 second video describing the ultrasound-guided brachial plexus block procedure, including ASA monitor attachment, IV cannula placement, patient positioning, and expected numbness from the shoulder to the fingertips for up to 6-8 hours. Link to Video 2 (https://drive.google.com/file/d/1FMljXB3kFbJDnD3PNgqVEbKPsRzD7hhX/view?usp= drivesdk)

For the NV group, the anaesthesia procedures (SA or BPB) were explained verbally by the anaesthesia team during the PAC, using the patients' preferred language.

On the day of the procedure, the APAIS was repeated prior to transferring the patients to the operating theatre. After the procedure, patient satisfaction with the anaesthesia experience was measured using the Likert scale.[10] This scale, translated into regional languages (Kannada, Malayalam, and Hindi), was administered to all patients before they were transferred from the recovery room to the wards.

The Likert scale used to measure patient satisfaction had five points: 1 for "Very Satisfied," 2 for "Satisfied," 3 for "Neutral," 4 for "Dissatisfied," and 5 for "Very Dissatisfied." All APAIS and Likert scale assessments were carried out by a single observer to ensure consistency in the data collection process.

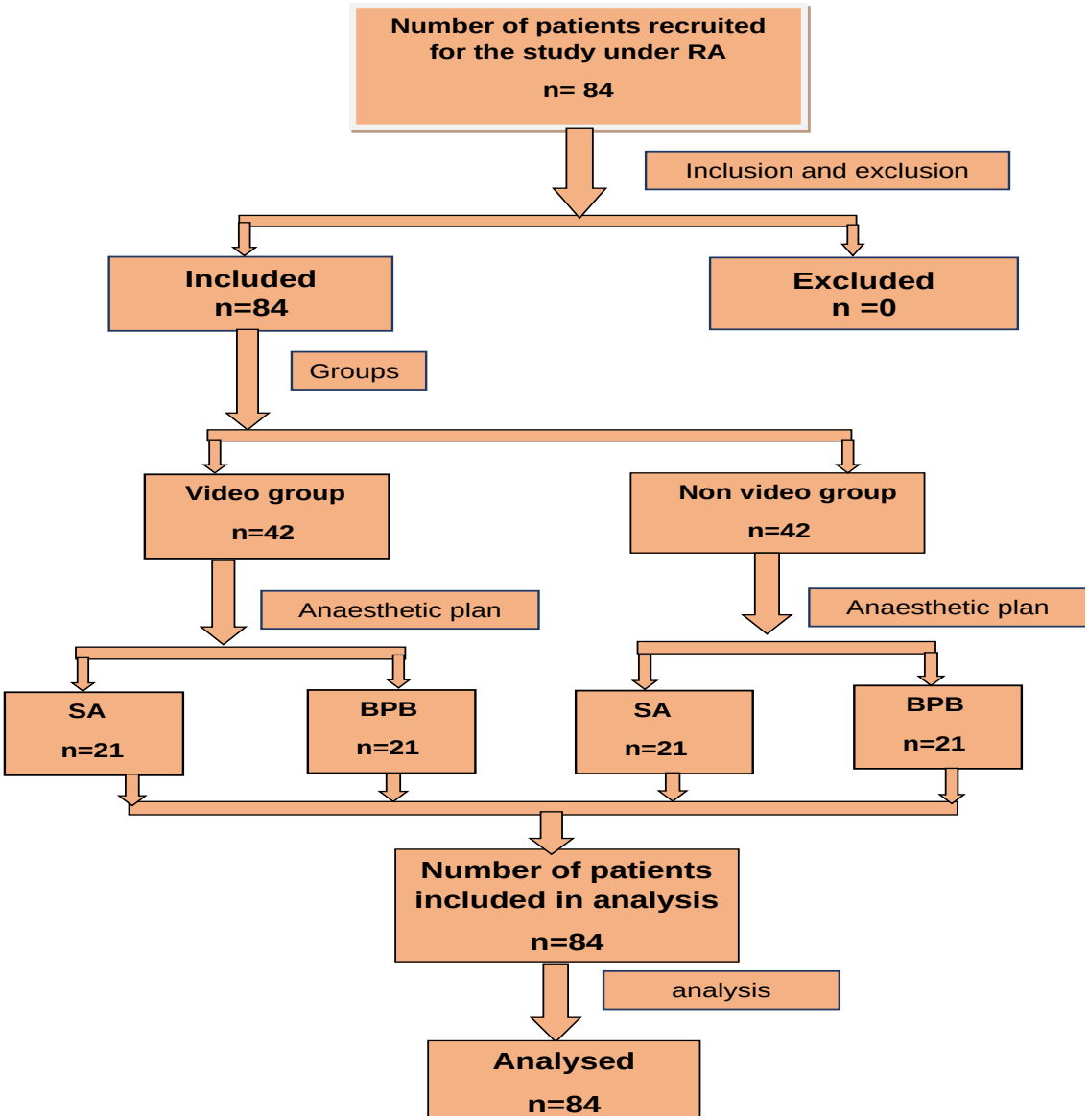

Figure 1: Consort diagram

3. Results

Data analysis was done using SPSS version 20, and the results were expressed in tables and figures. P-values < 0.05 were considered statistically significant for all data. Continuous data were reported using means, standard deviations, and percentages as applicable. The means were compared using independent sample t test and chi square test. The Chi square test was applied to determine the relationship between anxiety score and information score among the groups. Both the groups were similar in terms of demographics such as age, height, weight and BMI. (**Table 2**).

The Chi-square test was utilized to compare the anxiety and information scores between the video and non-video groups. Significant differences ($p < 0.05$) were observed in both the anxiety scores on the day of surgery, as well as in the information scores during the pre-anaesthesia consultation (PAC) and on the day of surgery between the two groups. (**Table 3**)

During PAC, in the non-video (NV) group, of the 42 patients, 24 (57.1%, CI: 0.5714±0.1544) experienced moderate anxiety, 13 (31%, CI: 0.3095±0.1532) had high anxiety, and 5 (11.9%, CI: 0.1190±0.0989) had low anxiety. On the day of surgery, 24 patients (57.1%, CI: 0.5714±0.1615) in the NV group had moderate anxiety, 12 (28.6%, CI: 0.2857±0.1342) had high anxiety, and 6 (14.3%, CI: 0.1429±0.1082) had low anxiety scores.

In the video (V) group, during PAC, 22 out of 42 patients (52.4%, CI: 0.5238±0.1540) had high anxiety scores, 15 (35.7%, CI: 0.3571±0.1530) had moderate anxiety, and 5 (11.9%, CI: 0.1190±0.0989) had low anxiety scores. On the day of surgery, 31 patients (73.8%, CI: 0.7381±0.1282) in the video group reported low anxiety, 11 patients (26.2%, CI: 0.2619±0.1343) had moderate anxiety, and none reported high anxiety scores.

Table 2: Comparison of age, height, weight, and BMI between the groups

		Mean	S.D.	"t"	p value
Age (Years)	Video group	48.0	12.6	1.08	0.284
	Non video group	44.9	14.1		
Height (Cm)	Video group	160.2	10.6	-0.22	0.830
	Non video group	161.0	19.6		
Weight (Kg)	Video group	62.0	10.8	-1.30	0.199
	Non video group	66.2	18.1		
BMI (Kg/M^2)	Video group	24.0	4.4	0.18	0.855
	Non video group	23.8	4.0		

("t" = Independent sample "t" test)

Table 3: Comparison of anxiety score and information score between groups

			Groups						Chi square	p value
			Video group			Non video group				
			n	%	CI	n	%	CI		
During PAC	Anxiety score	Low	5	11.9	0.1190±0.0989	5	11.9	0.1190±0.0989	4.39	0.111
		Moderate	15	35.7	0.3571±0.1530	24	57.1	0.5714±0.1544		
		High	22	52.4	0.5238±0.1540	13	31.0	0.3095±0.1532		
	Information score	Low	1	2.4	0.0238±0.2990	9	21.4	0.2143±0.2637	18.91	< 0.001*
		Moderate	16	38.1	0.3809±0.2374	26	61.9	0.6190±0.1683		
		High	25	59.5	0.5952±0.4300	7	16.7	0.1667±0.2757		
On the day	Anxiety score	Low	31	73.8	0.7381±0.1282	6	14.3	0.1429±0.1082	33.72	< 0.001*
		Moderate	11	26.2	0.2619±0.1343	24	57.1	0.5714±0.1615		
		High	0	0	0	12	28.6	0.2857±0.1342		
	Information score	Low	42	100	1.0	25	59.5	0.5952±0.1484	21.31	< 0.001*
		Moderate	0	0	0	17	40.4	0.4048±0.1484		
		High	0	0	0	0	0	0		

Table 4: Comparison of patient satisfaction between groups

		Groups						Chi square	p value
		Video group			Non video group				
		n	%	CI	n	%	CI		
Patient satisfaction	Very satisfied	21	50	0.5±0.1513	14	33.3	0.3333±0.1444	7.83	0.020*
	Satisfied	20	47.6	0.4762±0.1425	19	45.2	0.4524±0.1435		
	Neutral	1	2.4	0.0238±0.0460	9	21.4	0.2143±0.1237		

Regarding anxiety scores, on the day of surgery, the video group demonstrated a significant reduction in anxiety levels compared to their baseline ($p < 0.001$). Notably, 73.8% (CI: 0.7381±0.1282) of the video group reported low anxiety, in contrast to only 14.3% (CI: 0.1429±0.1082) in the NV group. (**Table 3**)

In terms of information scores, patients in the video group expressed a significantly lower need for information on the day of surgery. All 100% of video group patients reported a low need for information, compared to 59.9% (CI: 0.5952±0.1484) in the NV group. This suggests that the video effectively addressed the informational needs of the patients

3.1. Patient satisfaction

The Chi square test was used to compare patient satisfaction between groups. There was a difference ($p < 0.05$) in patient satisfaction between the video group and non-video group.(**Table 4**)

The video group patients showed higher level of satisfaction with 50% (CI- 0.5±0.1513) being very satisfied compared to 33.3% (CI-0.3333±0.1444) in NV group ($p = 0.020$).

4. Discussion

The primary objective of this study was to assess pre-anaesthetic anxiety scores in patients undergoing elective surgery under regional anaesthesia (RA) using the APAIS scale, both before and after providing video-based information about the regional anaesthesia techniques. The study found that patients who viewed a pre-anaesthetic informational video about the regional anaesthesia procedures (spinal anaesthesia for lower limb surgeries and brachial plexus block for upper limb surgeries) demonstrated significantly lower anxiety on the day of surgery compared to those who did not view the video ($p < 0.001$).

During the initial pre-anaesthesia consultation (PAC) on the preoperative day, 52.4% of the video group patients had high anxiety, as indicated by their APAIS scores. However, this decreased to 26.2% on the day of surgery. The percentage of patients with low anxiety scores, which was found in only 5 out of 42 patients (11.9%) during PAC, increased to 33 patients (73.8%) on the day of surgery. In contrast, moderate to high anxiety scores were noted in 88.1% of patients in both groups during PAC. After watching the video, 26.1% of patients in the video group had moderate anxiety scores on the day of surgery, while 85.7% of the non-video group still reported moderate to high anxiety. Notably, nobody in the video group had high anxiety scores on the day of surgery, clearly demonstrating the beneficial impact of an informative procedural video in reducing preoperative anxiety.

The study also revealed that the need for information about the anaesthetic procedures was 59.5% in the video group and 61.9% in the non-video group during PAC. However, on the day of surgery, 100% of patients in the video group reported a low need for information, indicating a significant reduction in the need for further information. In contrast, the need for information remained unchanged at 59.5% in the non-video group. These differences were statistically significant ($p < 0.001$), indicating that viewing a pre-anaesthetic video not only reduced anxiety but also significantly impacted the need for information among surgical patients. This underscores the important role of patient education provided through multimedia video.

Additionally, there was a significant difference ($p = 0.020$) in patient satisfaction between the video and non-video groups. It is important to note that both multimedia and verbal information about regional anaesthesia techniques effectively reduced overall patient anxiety related to anaesthetic procedures. During PAC, 41.7% of patients in both groups had high anxiety scores, which dropped to 14% on the day of surgery. A significant reduction in information scores was observed across all patients.

The findings of this study are consistent with previous research that assessed the impact of preoperative multimedia videos in alleviating patient anxiety. These results align with those of studies conducted by several researchers,[1,6,8,11-14] further validating the role of multimedia patient education in reducing preoperative anxiety and enhancing patient satisfaction. Several validated questionnaires, including the Amsterdam Preoperative Anxiety Information Scale (APAIS), the State-Trait Anxiety Inventory (STAI), and the Visual Analogue Scale (VAS), are commonly used for evaluating preoperative anxiety due to their ease of administration, low cost, and convenience. However, as observed by Dias R et al.[1] the use of the STAI for anxiety assessment posed a limitation in that it could only be administered to literate patients, excluding a significant portion of illiterate individuals from the study. To overcome this limitation, the current study employed the APAIS, which

has a strong correlation of 0.74 with anxiety and a weaker correlation of 0.16 with the information category when compared to STAI.[9]

While the present study focused on videos detailing the procedural aspects of spinal anaesthesia and brachial plexus blocks, with the risks and complications explained verbally in both the video and non-video groups, this approach differs from that of Jlala et al.[6] who included videos not only on the procedure but also covering risks, benefits, alternatives, and technical details of regional anaesthesia (RA). Additionally, Jlala et al. measured anxiety using both STAI and VAS, which provided a broader understanding of patient anxiety compared to the APAIS used in this study.

In line with previous findings, Matthey P W et al. concluded that public perception of RA often includes unfounded fears about complications, suggesting that the public's understanding of regional anaesthesia is often distorted.[5] The current study reinforces this idea by showing that multimedia information can effectively educate the public, help alleviate misconceptions, and reduce fears related to the risks of RA.

Moreover, the findings of the present study are in agreement with Klopfenstein CE et al.,[15] who emphasized that time during the pre-anaesthetic assessment should be utilized for patient education, as it can lead to a significant reduction in patient anxiety. Educating patients during this period not only improves their understanding of the procedure but also contributes to a more relaxed and informed approach to the anaesthesia process.

However, the results of this study diverge from those of other research, such as the studies by Matterlin T et al. and others which did not find any significant effect of video information in reducing preoperative anxiety.[16,17] Notably, Matterlin T et al. did not measure anxiety levels before the intervention, such as the video or interview, which could have provided a clearer understanding of the intervention's impact on anxiety. The omission of baseline anxiety measurements in these studies may have contributed to the lack of observed effect, highlighting the importance of comparing pre- and post-intervention anxiety levels to assess the true impact of multimedia information on patient anxiety.

The primary focus of the study by Matterlin T et al. was to evaluate how much the duration of the pre-anaesthesia interview could be reduced in patients who watched a 10–15-minute video providing general information about their anaesthetic procedure.[16] Their conclusion was that the value of a personal interview could not be fully replaced by video. The limited benefits observed in their study could be attributed to the general, non-specific nature of the information provided, which contrasted with the more detailed and procedure-specific information provided in the current study. Based on these findings, it is recommended to combine a personal pre-anaesthetic interview with an educational video, rather than relying solely on multimedia information.

Likewise, Salzwedel C et al. conducted an RCT examining the impact of detailed video-assisted anaesthesia risk education on reducing patient anxiety. They measured anxiety using VAS and STAI scores in general anaesthesia (GA) cases and concluded that while video information increased patient knowledge, explicit videos focused on risks actually increased patient anxiety.[17] However, the current study did not include videos focusing on risks or complications, making it difficult to draw direct comparisons on this parameter. Nonetheless, Salzwedel C et al. pointed out that the timing of the video did not affect knowledge transfer or patient satisfaction. In line with their observation, the reduction in anxiety scores in the present study was specifically noted when the video was shown during the pre-operative consultation (PAC) on the preoperative day.

This study further observed that the use of audio-visual information during PAC, as opposed to relying solely on standard verbal explanations, enhanced patient care by improving their understanding of the regional anaesthesia procedures. The combination of visual and audio content allowed patients to better grasp what to expect before, during, and after the procedure. The videos also served to address common misconceptions and provided consistent, standardized information that patients might hesitate to ask their healthcare provider. This not only improved patient comprehension but also supported better information retention and engagement. The findings of the current study, including lower information scores on the day of the procedure in the video group, further highlight the effectiveness of multimedia tools in improving communication and reducing the need for additional informational support.[18]

The study also had several limitations. First, the sample size was relatively small, which may limit the generalizability of the results to a larger population. Observer bias cannot be ruled out since the same person assessed the APAIS score on both days, and the interviewer was not blinded to the intervention the participant had received. Additionally, the NV group could have been provided with a printed brochure containing details about the RA procedure, which might have helped reduce the information and knowledge bias between the two groups. The study design also did not allow for assessing the amount of information retained by the study participants after watching the video. Moreover, the study relied on self-reported anxiety levels assessed using the APAIS scale, which may be subjective and influenced by factors such as patient mood and perception. Employing objective measures or combining multiple assessment tools could enhance the accuracy of anxiety evaluation.

Multimedia teaching methods effectively reduce preoperative anxiety in RA patients. Customizing videos based on literacy levels and demographics may enhance their

effectiveness. Future research should explore the impact of various surgical procedures on anxiety levels and investigate the long-term effects on recovery, complications, and hospital stays. Such interventions have the potential to improve patient experiences and overall surgical outcomes.

5. Source of Funding

None.

6. Conflict of Interest

None.

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