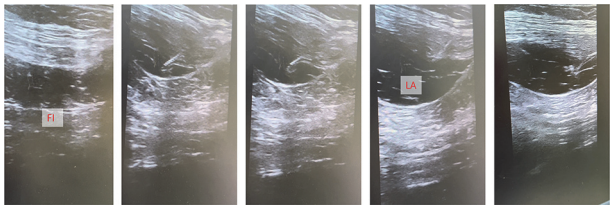
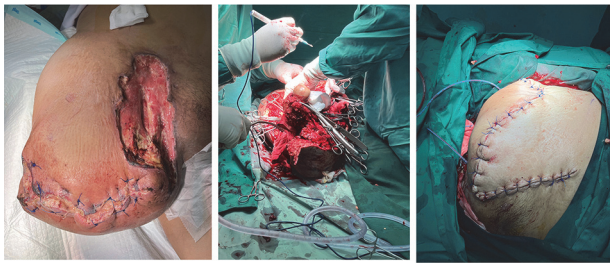
peripheral vascular disease and prior above knee amputations. Peripheral nerve block serves as a good alternative for both intraoperative and postoperative analgesia. This case report aims to describe the role of suprainguinal fascia iliaca block for hip disarticulation surgery.

Methods A 54-year-old male, presented with large inguinal ulcer and stump ulcer following above knee amputation due to peripheral arterial disease. Patient had history of chronic renal disease on routine dialysis, congestive heart failure with low ejection fraction, diabetes mellitus, and valvular heart problem. He was still on both oral clopidogrel and cilostazol. General anesthesia was conducted with fentanyl and ketamine as induction agents then central line was inserted. Suprainguinal fascia iliaca block was attempted with 40 mls of ropivacaine 0.375%; then continuous catheter was inserted after successful single shot block. Intraoperatively, hemodynamic was stable and no additional opioid was administered. Postoperative pain management included continuous ropivacaine 0.2% 10 ml/hour, oral paracetamol, and gabapentin. Patient reported minimal pain at 24 hours postoperative.

Results Hip disarticulation surgery is relatively rare procedure with challenging anesthesia management, especially when it is delivered in high-risk patients. Peripheral nerve block, including suprainguinal fascia iliaca block, may provide beneficial alternative for both intraoperative and postoperative analgesia.



Abstract #36338 Figure 1 Suprainguinal fascia iliaca block



Abstract #36338 Figure 2 Clinical pictures of hip disarticulation surgery due to stump and inguinal ulcer following above knee amputation

Conclusions Suprainguinal fascia iliaca block serves as relatively simple and safe peripheral nerve block for hip disarticulation surgery in high-risk patients.

#34467 AWAKE CRANIOTOMY WITH SLEEP-AWAKE-AWAKE TECNIQUE

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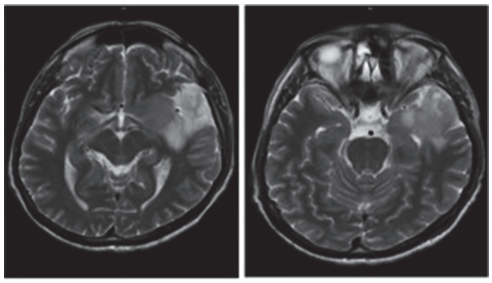
Application for ESRA Abstract Prizes: I don't wish to apply for the ESRA Prizes

Background and Aims The goal of case report is the management of awake craniotomy with sleep-awake-awake tecnique. An awake craniotomy is a surgical procedure in which patient is deliberately kept awake during whole surgical process or a portion of surgery.

Methods The patient was a 49-year-old male; MRI revealed a 42x38 mm glial tumor in the temporal region, close to Broca area, in the structures of the neurosurgery clinic with a complaint of headache. A craniotomy with scalp block was planned for the patient. Consent was obtained after preoperative information was given. Standard anesthesia monitoring (ASA) was performed on the patient. We planned the sleep-awake-awake technique in awake craniotomy. In induction, 2.5mg/kg of propofol, 1.5mcg/kg of fentanyl and 1mg/kg of lidocaine were administered. A supraglottic airway device, I-gel, is inserted. Then, scalp block was performed with 0.5% bupivacaine. Neurosurgeon applied Mayfield pine. As neurosurgeon approached where the tumor was located, the stage of awakening the birth was started. Before these steps, a loading dose of dexmedetomidine 1mcg/kg was given as a 15-minute infusion in 100cc fluid, and 0.2mcg/kg/hour was switched to maintenance. Remifentanil and sevoflurane are reduced and turned off after 15minutes. The patient whose spontaneous breathing started was awakened, and i-gel laryngeal mask was removed. The patient was talked to every 3-5 minutes until the tumor area was reached and controlled by starting the engine. The patient would talk long enough to answer the questions.



Abstract #34467 Figure 1 Patient MRI

Results Awake craniotomy is multidisciplinary teamwork, and the anesthesiologist should know for various purposes, scalp blockage, and forward referral management.

#36481 COMBINED US-GUIDED ERECTOR SPINAE PLANE BLOCK (ESP) + PARASTERNAL BLOCK (PSB): NEW PERSPECTIVES IN OPIOID-FREE ANESTHESIA FOR ONCOLOGICAL MAJOR BREAST SURGERY

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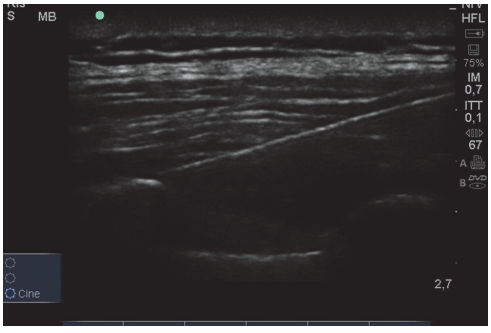
Background and Aims In breast surgery, locoregional anesthesia has shown its effectiveness in pain management and in preventing the onset of post-mastectomy pain syndrome (PMPS). In particular, a totally opioid-free approach can be reserved for fragile patients. We experienced a series of ESP block and parasternal (PSB) block combination as a new approach for analgesia in modified radical mastectomy (MRM).

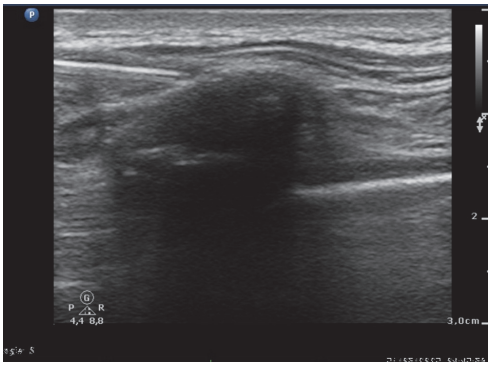
Methods We selected five patients from 34 to 68 years old who underwent a modified radical mastectomy; ESP block was performed at T5 level with 25 ml of ropivacaine 0,5% and PSB block was administered with 10 ml of ropivacaine 0,5% between II and IV ribs for a better cover of the anteromedial wall chest. Patients underwent general anesthesia with a supraglottic device and opiods were given neither during or after surgery. Intravenous Paracetamol was provided every 8 hrs for 24 hrs.

Results Pain score in a NRS scale, mgs of morphine demanded by patients and presence of PONV were recorded. Four of five patients reported a pain score

<3 on the NRS scale, only 1 patient required 1 mg of morphine at 6 hrs with a score of 5 on NRS scale. No other symptoms were described. Furthermore, at a three-month post-operative follow-up, no pain >2 on the NRS scale was reported.



Abstract #36481 Figure 1 US-guided ESP block usually performed in prone position at T5 level right before general anesthesia



Abstract #36481 Figure 2 US-guided PSB performed between the pectoral major muscle and the internal intercostal muscle right after putting the patient under general anesthesia

Conclusions Combination of ESP block + PSB block has shown efficacy in ensuring good pain management during and after MRM in a totally opioid-free anesthesia perspective. Moreover, the low onset of pain at three months suggests its potential in PMPS prevention.

Point-of-care ultrasound use (POCUS)

#35836 DEVELOPMENT OF AN INSTITUTIONAL GUIDELINE FOR CLEANING AND DISINFECTION OF SURFACE US PROBES

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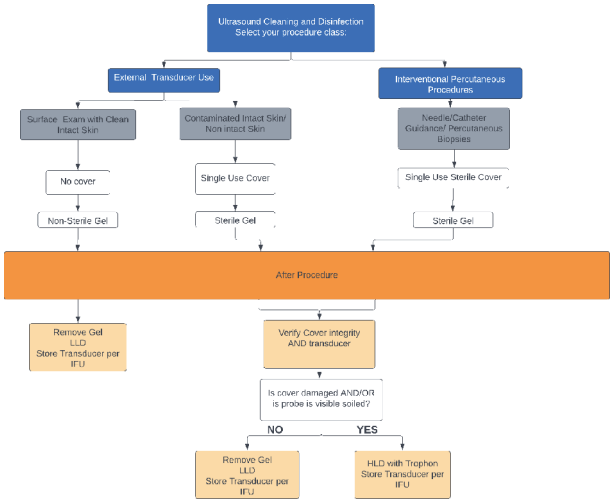
Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

Background and Aims The use of ultrasound (US) in perioperative settings has significantly increased due to its assistance capabilities. However, there is a lack of standardized guidelines for their cleaning and disinfection. There are conflicting instructions between probe manufacturers, as well as inconsistencies and lack of regulation from regulatory agen

Methods A comprehensive review of existing literature, manufacturer IFUs, regulatory guidelines (FDA, CDC, Joint Commission) and the American Institute of US Medicine statement supported by over 20 professional societies was conducted to identify the current best practices and gaps in knowledge. An interdisciplinary task force consisting of anesthesiologists, infection control specialists, biomedical engineers, and sterile processing experts developed the guideline.

Results The task force developed a step-by-step guideline that encompasses appropriate cleaning techniques, disinfectant selection and quality assurance measures. It has been approved by stakeholders identified in all other departments where Surface US is heavily used (vascular medicine, Ob/Gyn, emergency medicine).



Abstract #35836 Figure 1 Flowchart