Invited speakers

SP1 FASCIAL PLANE BLOCKS: GAME CHANGERS IN PAEDIATRIC ANAESTHESIA

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The first significant cornerstone of regional anesthesia, which has led to its widespread use, is the clinical utilization of ultrasound in block applications. Moreover, many different fascial plane block techniques have been described in parallel with the progress in knowledge in sonoanatomy and the success of the previously defined methods. It could be said that the next big step, especially for 'pediatric regional anesthesia', is the implementation of fascial plane blocks in daily practice.

Caudal block has long been the most applied technique for the pediatric age group. However, as known, the limited indications of caudal blocks along with the refrained complication profile make clinicians hesitate. So the clinical practice was limited to some classic best-known techniques and some experienced practitioners. Unfortunately, it is a well-known fact that 80% of pediatric patients undergoing surgery experience postoperative pain due to inadequate analgesia, and this undertreatment could lead to the development of chronic pain.[1] A multicentric study showed that chronic pain could be seen up to 6.6% after common surgeries in pediatrics.[2] With the introduction of 'Fascial Plane Blocks' into the practice, the clinicians started to have many options for daily cases. The simplicity, safety, and ease of the learning curve of these techniques make them find their place in current practice. Fascial plane blocks provide new avenues for delivering opioid-sparing analgesia while minimizing invasiveness and risks associated with older techniques. They are safe and effective options for treating acute postoperative pain and for both the treatment and prevention of chronic pain in infants and children.

Transversus abdominis plane(TAP) block might be the first 'game-changer', but now the trend is going on with multiple novel fascial plane blocks covering various sensory distributions. However, the data about these blocks are limited, and the debate about their efficacy continues.

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SP2 PDPH IN NON-OBSTETRIC POPULATION. A PROBLEM OR MYTH?: MYTH

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In 1885, Dr. JL Corning[1] wrote the first paper about spinal anesthesia and said, 'Whether the method will ever find an application as a substitute for etherization in genito-urinary or other branches of surgery, further experience alone can show'. He might have been defined the very first post-dural puncture headache (PDPH) in that first report of the spinal anesthesia application, instead of August Bier. In 1956 it was reported that the incidence of PDPH was varied between 15% to 46%.[2] And current reports show that the incidence of unintended dural puncture (DP) is between 0,16%-1,3%, and the incidence of PDPH after DP ranges between 16% to 86%.[3] This means that the 'so-called problem' occurred in 0,02%-1,1% of the patients. But is this a problem or a complication that can be overcome?

It is known that the development of PDPH depends on several factors related to the patient, the technique, and the needle type.[4] Pirbudak et al.[5] showed that the physician's experience and physical state/fatigue are strongly correlated to the incidence of PDPH along with other well-known factors. So this leads us to think that 'the problem' is not PDPH itself, but might be the lack of experience, lack of knowledge for both prevention and treatment, and improper technique or needle.

Today, when we search for 'spinal anesthesia' on Pubmed, nearly 28000 results can be found. Some of these are about the complications like PDPH, but most are about the benefits of the technique. One way or other, since its first definition, the technique has found its place in daily clinical practice as a standard procedure. I have two questions: If PDPH is a real problem, why do the clinicians continue to perform spinal anesthesia. And is it really a problem, as there are many solutions?

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SP3 BEST RA TECHNIQUE FOR ANKLE AND FOOT AMBULATORY SURGERY

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Peripheral nerve blocks are highly effective anaesthesia and analgesia technique with low technical risk for ankle and foot surgery, They are appropriate and convenient technique for Ankle and foot Ambulatory surgery.

Depending of the tourniquet positioning the anaesthesia of the Ankle and foot can be organized using proximal or distal block. Proximal blocks are necessary when using a thigh tourniquet and distal blocks are efficient when using an ankle tourniquet.

1. Thigh tourniquet with proximal blocks for ankle and foot surgery.

   Using a thigh tourniquet, a sciatic and femoral nerve blocks should be performed.[2]

   1–1 Femoral nerve block:

   When using an in plane technique, the puncture site is located at the outer lateral end of the probe. Advance the needle parallel to the long axis of the probe in the same plane as the ultrasound beam in the direction of the femoral