Abstract B42 Figure 3  Likelihood of performing ultrasound-assisted CNB after receiving training (scale 1–5, where 1= unlikely and 5= most likely)

20% of respondents highlighted concerns. These included the perceived additional time needed in emergencies, the availability of an ultrasound machine, patient safety and deskilling in the traditional landmark approach.

93% replied that ultrasound decreases number of attempts and improves accuracy of vertebral level identification.

87% suggested regular practical teaching sessions to improve confidence.

Conclusions The majority of anaesthetists in our hospital have no or very little experience in ultrasound-assisted CNB and were not confident to perform this technique. Replies suggested that lack of training and limited equipment are barriers to regular use. We intend to address these concerns with regular training sessions and promote the availability of a dedicated ultrasound machine on the maternity ward.

B43 ENCOURAGING THE USE OF ULTRASOUND-ASSISTED CENTRAL NEURAXIAL BLOCKADE ON PARTURIENTS

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Background and Aims We conducted a quality improvement project for 4 months between November 2021 to March 2022 to encourage the use of ultrasound-assisted epidural/spinal anaesthesia on maternity ward to improve patient care by reducing the number of needle puncture attempts.

Methods All anaesthetists who performed epidural or spinal anaesthesia on parturients were asked to document the number of skin puncture attempts and whether ultrasound was used.

Throughout the data collection period, regular targeted teaching sessions on central neuraxial ultrasound for anaesthetists were provided by an experienced regional anaesthetist at the William Harvey Hospital.

Results An increase from 1 ultrasound-assisted epidural/spinal in the first month to 11 in the 3rd month was noted following targeted teaching sessions along with a reduction in needle-puncture attempts, as demonstrated by Figure 1 and 2.

Conclusions The data demonstrates that the use of ultrasound for central neuraxial blockade on parturients is very low and further engagement is required to change practice. This may include targeted teaching sessions to anaesthetists by an experienced practitioner and increasing awareness amongst anaesthetists about the benefits of using ultrasound.

Although no statistical analysis of the data was performed, a trend towards increased ultrasound use has been noted following targeted ultrasound teaching sessions. This may in turn have some role to play in the reduction of needle puncture attempts demonstrated by the data.

B44 THE MISSING SUPERIOR TRUNK

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Background and Aims The brachial plexus is a complex anatomical structure and its variability is frequently observed. [1] Some rare arrangements of the plexus might represent a challenge even for experts in regional anesthesia.

Ultrasound scanning gave us the chance to identify and illustrate a very rare variant of the brachial plexus, never described so far (figure 1)
Abstract B44 Figure 1

Methods A 29-year-old female resident was selected as a model for a live demonstration regarding ultrasound guided regional anesthesia.

Results Scanning on the right side of the neck: C5 – emerges between anterior and posterior tubercles of C5 transverse process (TP); courses anteriorly to the anterior scalene muscle (ASM), then becoming superficial, goes back, and dives into the interscalene groove alone without joining the C6 root. C6 and C7 – emerge from the corresponding TP, run inside the interscalene groove, joining each other below the transverse cervical artery (TCA), forming a sort of trunk.

C8 – becomes visible in the corner pocket and immediately joins the trunk.

T1 – never becomes visible

TCA level: C5 root and the trunk are clearly visible; a fascial sheet keeps them divided. (figure 2) The course of the plexus is visible in a video linked to the QR code in the figure.

The contralateral plexus was perfectly normal.

Abstract B44 Figure 2

Conclusions This rare anatomical variation might represent a challenge in case of interscalene block. Since the upper trunk does not exist, a superior trunk block (STB) [3] would be impossible. An accurate ultrasound examination, aiming to recognize standardized structures [2] would be helpful.

Background and Aims The dorsal penile nerve block (DPNB) is an effective regional anesthesia technique for common procedures including circumcision, urethral surgery and urgent penile interventions. The in-plane ultrasound-guided approach reduces adverse events and improves its efficacy. Nevertheless, space conflict between probe, needle and tissues, along with the risk of local hematoma formation, remain a source of concern.

Methods Consent was obtained from patient’s legal representative.

Results We hereby describe the case of a healthy 4-year-old male patient scheduled for distal hypospadias repair under general anesthesia and DPNB. An ultrasound-guided in-plane approach was used, with the probe transversely positioned at the base of the dorsal aspect of the penis. The needle was advanced piercing Buck’s fascia and 3.5 mL of 0.25% levobupivacaine were administered, initially dissecting the fascia, which was rapidly corrected by needle adjustment. The surgery was uneventful despite the swelling of the dissected tissues, with same-day discharge. The 5th day postoperative consultation revealed a hematoma of the penis and scrotum.

Abstract B45 Figure 1

ULTRASOUND-GUIDED DORSAL PENILE NERVE BLOCK GONE WRONG – HOW CAN WE REDUCE THE RISKS?

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Abstract B45 Figure 2