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.

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Conclusions The DPNB is a useful resource in elective and emergency settings. The ultrasound-guided approach is now considered the mainstay of regional anesthesia delivery despite not being free of complications. Is it possible to further reduce the risks? The authors suggest the in-plane approach with the probe transversely positioned at the base of the ventral - rather than dorsal - aspect of the penis; its routine use would allow more space for needle adjustments and better visualization of structures, thus reducing the risks associated with the DPNB in the pediatric population.

**Background and Aims**

Use of ultrasound has revolutionized Regional Anesthesia techniques to provide adequate surgical anesthesia. Blockage of Sciatic nerve in popliteal fossa is common technique for surgeries involving foot & ankle. There are various approaches described to perform block. We decided to do observational study on volunteers for comparing posterior & lateral approach on following parameters:1. Need for external assistance for positioning2. Time taken to localize sciatic nerve3. Patient comfort4. Anesthetist satisfaction score.

**Methods**

Scanning was done by same anesthetist with same machine in all volunteers. Time was recorded starting from positioning till sciatic nerve was localized. Fifty volunteers were divided in two groups on random basis.

1. GroupP [Posterior approach]: Scanning was performed in lateral decubitus or supine with knee flexed position. High frequency transducer placed in transverse position at Popliteal crease and Popliteal artery identified. Superficial and lateral to it hyperechoic oval/round structure tibial nerve identified. Transducer scanned proximally till tibial and peroneal nerve joined to form sciatic nerve.

2. GroupL [Lateral approach]: Scanning performed in supine position with limb in neutral position. Transducer placed in transverse position perpendicular to skin proximal to popliteal crease level. Scanning done proximally till hyperechoic sciatic nerve surrounded by hypo echoic muscles & hyper echoic shaft femur shadow identified.

**Results**

No external assistance for positioning needed in GroupL compared to GroupP. No adjustments in limb position needed in GroupL while flexion/extension of hip needed in GroupL. Time to localize nerve was less in GroupL. Anesthetist satisfaction score higher in GroupL.

**Conclusions**

We concluded that Lateral approach is simple & convenient for both patients and anesthetists & should be practiced more often.