

**Background and Aims** There is no evidence on analgesia or sedation concepts during pre-operative placement of peripheral nerve block. Aim of our RCT pilot trial was to estimate the best practice approach for analgosedation for regional anaesthesia.

**Methods** 50 patients participated the study from 08/2020–12/2020. Computer-based randomization was performed to one of five treatment concept groups:

1. Remifentanyl-Infusion (no bolus, 6–9 mcg/kg/h i.v.),
2. Fentanyl-Bolus (100 mcg i.v. for BW>50 kg and 50 mcg for BW< 50 kg),
3. Clonidine 150 mcg bolus i.v.,
4. Lidocaine/Prilocaine topical cream 30 min prior to the puncture,
5. Placebo.

Pain intensity at skin puncture with 22-G 50 mm and 21-G 100 mm needles was the main outcome, assessed by a numeric pain scale (NRS) at the time of a needle insertion, as well as patients' satisfaction and wellbeing (Anaesthesiological Questionnaire).

(Ethical Committee No. 31–255 ex18/19)

**Results** There were no statistical differences between the baseline characteristics. No significant difference in favour of any analgosedation concept regarding pain reduction or wellbeing. Remifentanyl infusion provided the lowest experienced pain levels (NRS 2,0 [1,5–3,0]) followed by Lidocaine/Prilocaine creme (NRS 2,5 [1,25–4,0]) and Placebo (NRS 2,5 [1,25–4,5]). No adverse effects (e.g. nonresponsiveness or drop in oxygen saturation or blood pressure, nerve injury) were revealed.

Abstract B58 Table 1

Outcome	Remifentanyl	Lidocaine/ Prilocaine	Fentanyl	Clonidine	Placebo	P
Pain at puncture (NRS)	2,00 [1,5 to 3,0]	2,50 [1,25 to 4,0]	3,00 [2,0 to 4,75]	4,00 [3,0 to 5,0]	3,00 [2,0 to 4,5]	0,172
Light pain (1 to 2)	7/9	6/12	5/12	1/9	3/8	0,80
Medium or strong pain (3)	2/9	6/12	7/12	8/9	5/8	
Wellbeing (ANP)						
None	0/9	1/12	0/11	0/9	0/8	0,535
Some	1/9	3/12	3/11	0/9	1/8	
Quite	6/9	7/12	8/11	9/9	6/8	
Strong	2/9	1/12	0/11	0/9	1/8	
Complications	None	None	None	None	None	n.a.

#### Conclusions

Further issue to investigate are, whether it is reasonable to reduce the pain intensity at the price of patients' vigilance. Analgosedation with remifentanyl seems to provide the lowest pain while best ensuring patients' wellbeing. Optimal approach has to be adjusted according to the patient needs, medical personnel expertise and a hospital's logistics.

#### B59 ANATOMICAL STUDY OF CATHETER MOBILIZATION AFTER PHYSIOTHERAPY IN CLASSICAL POSTERIOR SUPRASCAPULAR NERVE BLOCK

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**Background and Aims** Continuous peripheral nerve blocks (cPNB) are widely used and have potential benefits for providing pain relief for several days. Successful insertion of cPNBs and avoidance of their dislocation can represent a challenge.

Dislocation of cPNBs can result in failure of the block and is poorly described in the literature. The rate of catheter dislocation is probably underestimated.

We designed an cadaveric anatomical study to assess the rate of catheter displacement after a simulated program of intensive physiotherapy. The aim was to compare the location of the catheter tip just after placement and after physiotherapy.

**Methods** Eight ultrasound guided continuous suprascapular nerve blocks were performed. The catheter tip localization was confirmed by tomodensitometry. We then simulated a physiotherapy session by performing a series of standardized movements on anatomical specimen. After marking with methylene blue, an anatomical dissection followed to localize the position of the catheter tip.

**Results** There was radiological evidence of correct placement in the vicinity of the suprascapular notch for all catheters.

Dissections demonstrated that in six specimens (75%), catheters remained in the correct place after physiotherapy.

Two catheters came out and escaped through supraspinatus muscle and trapezius.

**Conclusions** From an anatomical point of view, catheter dislocation of continuous suprascapular nerve blocks after an intense program of physiotherapy of shoulder mobilization, occurs in 25% of cases.

#### B60 IPACK AND ACB VERSUS PERIARTICULAR INJECTION (PAI) ENHANCES POSTOPERATIVE PAIN CONTROL IN ANTERIOR CRUCIATE LIGAMENT (ACL) REPAIR: A RANDOMIZED CONTROLLED TRIAL

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**Background and Aims** Periarticular injections (PAIs) are becoming a component of multimodal joint pathways. Motor-sparing peripheral nerve blocks, such as the infiltration between the popliteal artery and capsule of the knee (IPACK) and the adductor canal block (ACB), may augment PAI in multimodal analgesic pathways for knee surgery, but supporting literature

remains rare. We hypothesized that t ACB and IPACK would lower pain on ambulation on postoperative day (POD) 1 compared to PAI alone.

**Methods** This triple-blinded randomized controlled trial included 50 patients undergoing ACL repair. Patients either received (1) a PAI (control group, n = 26) or (2) an iPACK with an ACB (intervention group, n = 24). The primary outcome was pain on ambulation on POD .Secondary outcomes included numeric rating scale (NRS) pain scores, patient satisfaction, and opioid consumption

**Results** Opioid consumption was different in both groups. Highly significant difference was also observed comparing the two groups concerning the total morphine consumption (mg) in the first 24 postoperative hours 6 mg in iPACK group compared to 11 mg in PAI group (p value=0.037). Pain upon ambulation was significantly less in iPACK group ( P value=0.01).The occurrence of postoperative nausea and vomiting was low in both groups with no statistical difference, this is most likely due to the prophylactic administration of dexamethasone and ondansetron given routinely to all patients

**Conclusions** The addition of iPACK and ACB significantly improves analgesia and reduces opioid consumption after ACL repair compared to PAI alone. This study strongly supports iPACK and ACB use within a multimodal analgesic pathway

#### B61 PREGNANT WOMAN WITH SUBDURAL CLINIC AFTER PROLONGED LABOR: A CASE REPORT

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**Background and Aims** Spinal analgesia is the technique for pain control of pregnant patients. There is a dural sac thickness space called “subdural spaced”. One of the causes of a failed epidural block is to inject local anesthetic into the subdural space, the clinic is a too high slow lock with a patched distribution, dyspnea and hypotension.

Other forms of subdural block are described in the literature , like for example Horner’s Syndrome wich is due to the block with local anesthetics of sympathetic fibers (C8-T1).

**Methods** 39 year old pregnant woman with no medical history of interest

Lumbar epidural catheter was inserted as analgesic treatment:

- Negative dose test
  - Negative aspiration test for blood and cerebrospinal fluid
  - Levobupivacaine 0,125%+200 mgr of fentanyl 12 mL/h
- Analgesia was not effective

New boluses of local anesthetic were injected with a new lumbar catheter.

After 180 minutes and prolonged labor, begins with blurred vision, miosis, ptosis and right enophthalmos wich is called unilateral Horner’s syndrome

**Results** The differential diagnosis of high spinal block with patchy distribution, asymmetric and minimal motor block compatible with subdural block is proposed.

Clinical symptoms compatible with cephalic distribution of local anesthetic until reaching the stellate ganglion of C8-T1 debuting as unilateral Horner’s syndrome.

**Conclusions** Most cases of Horner’s Syndrome described in neuroaxial anesthesia are related to pregnant patients. The

increased intra-abdominal pressure of pregnancy accompanied by prolonged labor during delivery and the increased sensitivity of the same seem to be predisposing factors. In most cases, they resolve spontaneously.

#### B62 PERIBULBAR AND SUB-TENON’S BLOCKADES: EFFECTIVE ANESTHETIC TECHNIQUES FOR EYE SURGERY IN A PATIENT WITH INFECTIVE ENDOCARDITIS – A CASE REPORT

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**Background and Aims** Infective endocarditis (IE) is a microbial infection of heart valves or mural endocardium, but mainly a multisystemic disorder.<sup>1</sup>Endogenous endophthalmitis is one of its complications. The literature is sparse about these two conjoint entities and anesthesia approach for patients with IE proposed for noncardiac surgery. We present a locoregional alternative to general anesthesia.

**Methods** A 64-year-old-woman, ASA IV, diagnosed with an endogenous IE by *Enterococcus faecalis* and concomitant endophthalmitis was proposed to vitrectomy.

The patient had two mechanical heart valves (aortic and mitral) since 2007 due to rheumatic disease and atrial fibrillation anticoagulated with warfarin.

With evidence of vegetations in mitral and tricuspid valves, six weeks of treatment with vancomycin and gentamicin were indicated.

After multidisciplinary discussion, benefits of ophthalmologic surgery seemed to outweigh the risks of delaying the procedure for six weeks for antibiotic treatment completion.

**Results** For vitrectomy, peribulbar and sub-Tenon’s blockades were performed using 3 and 4 mL of ropivacaine 1%, respectively, with further application of Honan balloon, under mild sedation with intravenous midazolam (total of 3mg) and alfentanil (total of 400mcg).

During the procedure (duration 100 minutes), hemodynamic stability and good surgical conditions were maintained.

The perioperative period was uneventful.

**Conclusions** IE is a systemic life-threatening disease, being prosthetic heart valves one of the major risk factors.<sup>1</sup>

Endogenous endophthalmitis is generally associated with high mortality and poor visual outcomes.<sup>2</sup>

Eye peripheral blockades decrease anesthetic risk.

Plus, avoiding general anesthesia and orotracheal intubation, the risk of endocarditis implantation in other prosthetic valves was reduced<sup>3</sup> and hemodynamic stability was maintained.

#### B63 SUPRAINGUINAL FASCIA ILIACA BLOCK FOR PERIOPERATIVE ANALGESIA IN TOTAL HIP REPLACEMENT: A RETROSPECTIVE ANALYSIS

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**Background and Aims** Suprainguinal fascia iliaca blocks can be used as part of peri- and postoperative pain management after total hip arthroplasty.<sup>1,2,3</sup> This study compares postoperative