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.

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**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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10.1136/rapm-2022-ESRA.137

**Background and Aims** Infective endocarditis (IE) is a microbial infection of heart valves or mural endocardium, but mainly a multisystemic disorder. Endogenous endophthalmitis is one of its complications. The literature is sparse about these two conjoin entities and anesthesia approach for patients with IE proposed for noncardiac surgery. We present a locorregional 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 alentanil (total of 400mg).

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. Endogenous endophthalmitis is generally associated with high mortality and poor visual outcomes.

Eye peripheral blockades decrease anesthetic risk.

Plus, avoiding general anesthesia and orotracheal intubation, the risk of endocarditis implantation in other prosthetic valves was reduced and hemodynamic stability was maintained.
morphine use and pain scores between patients with a suprapingual fascia iliaca block (FIB) with ropivacaine 0.375%, 40 mL and a control group (NB).

Methods We conducted a retrospective, single-center study reviewing all data of elective total hip arthroplasties performed between April 2019 and May 2021. Primary endpoint is patient-controlled intravenous (PCIA) morphine use at 24 hours. Secondary endpoints were PCIA morphine use at 48 hours, NRS pain scores, perioperative sufentanil-, postoperative IV piriramide consumption on the PACU ward and nausea. The ethical committee of the Imelda hospital in Bonheiden deemed ethical approval unnecessary.

Results Our study included 277 patients, consisting of 203 patients in the FIB group and 74 in the NB group. There was a significant decrease in PCIA morphine use (p = 0.000034) at 24 hours, lower pain scores at 48 hours (p = 0.0003) and lower sufentanil consumption perioperatively (p = 0.015) in the FIB group. However, pain scores and piriramide consumption in the PACU ward were significantly increased (p = 0.02 and p = 0.014, respectively) in the same group. No difference was reported for PCIA morphine use at 48 hours, pain scores at 24 hours and nausea.

Conclusions A preoperative suprapingual fascia iliaca block leads to less PCIA morphine consumption the first 24 hours, lower NRS pain scores at 48 hours and lower perioperative opioid need for total hip arthroplasty.

Abstract B63 Table 1

<table>
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<tr>
<th>Morphine</th>
<th>Mean</th>
<th>Median</th>
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<th>Q3</th>
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<td>24 hours</td>
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<td>5</td>
<td>2</td>
<td>9</td>
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</tr>
<tr>
<td>48 hours</td>
<td>6.5</td>
<td>3</td>
<td>1</td>
<td>10.5</td>
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</table>

Abstract B64 COMPARISON OF SUPRAPINGUAL FASCIA ILIACA AND PENG BLOCKS ON POSTOPERATIVE PAIN AND FUNCTIONAL RECOVERY AFTER TOTAL HIP ARTHROPLASTY: PRELIMINARY RESULTS OF A NON-INFERIORITY TRIAL

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Background and Aims Pain after posterolateral-approached total hip arthroplasty (PLTHA) may affect early functional recovery. Supra-inguinal fascia iliaca (SFICB) and percapsular nerve group blocks (PENG) have been proposed as promising analgesia techniques. 1-3 This trial was conducted to assess non-inferiority of PENG as compared to SFICB for controlling postoperative pain. Secondary outcomes included several assessments functional recovery.

Methods After approval by our local Ethics Committee (2020/381), forty-three patients scheduled for PLTHA with spinal anesthesia were prospectively and randomly allocated to groups. Group S and Group P received SFICB (40 mL ropivacaine 0.375%) or PENG (20 mL ropivacaine 0.75%), respectively. A blinded observer evaluated rest and mobilization pain on a 0–10 numeric rating scale (NRS) at fixed time points: 1h and 6h after surgery, at day-1 and day-2 at 8am, 1pm and 6pm. At day-1 and day-2, evolution on quality-of-recovery-15 score (QoR-15), timed-up-and-go (TUG), 2-minutes (2MWT) and 6-minutes-walking (6MWT) tests were performed. Non-inferiority margin was set as 1 NRS point 6 hours after surgery. Data were analyzed using Mann-Whitney or generalized linear mixed model tests as appropriate.

Results 6-hours after PLTHA, group PNRS was non-inferior to group S NRS (Figure 1A). Groups had no significant differences regarding rest and dynamic pain trajectory during the first 48 postoperative hours (Figure 1B), as well as regarding motor and functional recovery at day-1 and day-2 as assessed by TUG, 2MWT, 6MWT and QoR-15 (Figure 2).