

Abstracts

Results 34 consultants completed the survey. 100% of respondents stated their department use single-shot FIB and, when used, it was usually by members of the emergency department (ED) team (82%) and without ultrasound (82%). No respondents stated their department use continuous FIB in the ED for NOF fractures.

Q1: On average, how many patients with fracture neck of femur do you manage per month?		
Answer choices	Responses	Percentage
<10	1	2.94%
>10	33	97.05%

Q2: For fracture neck of femur does the mode of analgesia in the Emergency Department include the following?		
Answer choices	Responses	Percentage
Single shot fascia iliaca compartment block	34	100%
Fascia iliaca block with continuous catheter	0	0%
Other Block	1	2.94%

Abstract B79 Figure 1

Q3. In your department when a Fascia Iliaca block is done is Ultrasound guidance used routinely?		
Answer choices	Responses	Percentage
Yes	6	18%
No	28	82%

Q4. If single shot fascia iliaca compartment block is given, who usually performs the block?		
Answer choices	Responses	Percentage
ED (doctor or ACP)	28	82.35%
Orthopaedic surgical team member	5	14.71%
Anaesthetic consultant/ registrar	1	2.94%
Anaesthesia associate	0	0.00%

Abstract B79 Figure 2

Q5. If a single shot fascia iliaca compartment block is used, do you usually repeat the block again if surgery is not performed in the next 24 hours?		
Answer choices	Responses	Percentage
Yes	8	23.53%
No	26	76.47%

Q6. If a fascia iliaca block with continuous catheter is used, who usually inserts the catheter? (If you do not use continuous blocks with a catheter, go to Q8)		
Answer choices	Responses	Percentage
Emergency Department Team (Doctor/ACP)	0	0.00%
Orthopaedic surgical team	1	25.00%
Anaesthetic consultant/trainee	3	75.00%
Anaesthesia associate (PA, ACCP etc)	0	0.00%

Q7. If you use fascia iliaca block with continuous catheter, do you use intermittent dosing or continuous infusion?		
Answer choices	Responses	Percentage
Intermittent dosing	2	100.00%
continuous infusion	0	0.00%

Abstract B79 Figure 3

Conclusions Single-shot FIB appears to be widely used for the management of NOF fractures within ED, is usually delivered by members of the ED team and without ultrasound guidance. Continuous FIB appears to be used very rarely in the management for NOF fractures. This survey will lead onto a large prospective trial to further evaluate the potential of continuous FIB.

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ERECTOR SPINAE PLANE BLOCK: A GAME-CHANGER FOR THE MANAGEMENT OF PERIOPERATIVE ANALGESIA IN MAJOR LAPAROSCOPIC ABDOMINAL SURGERIES?

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Background and Aims Nowadays, even major abdominal surgeries are performed laparoscopically. However, patients complain for severe postoperative pain and the role of the anesthesiologist for its effective management remains crucial. In this case series, we evaluated the efficacy of continuous bilateral Erector Spinae Plane Block (ESPB) for the management of perioperative pain of patients undergoing major laparoscopic abdominal surgery.

Methods We enrolled four patients undergoing laparoscopic pancreaticoduodenectomy, laparoscopic hepatectomy and laparoscopic Nissen fundoplication surgery. Ultrasound-guided ESPB was performed in all patients 30 minutes before induction of general anesthesia at T9 level. Ropivacaine 0.375% (20 ml) was infused at each side 30 minutes before the induction of general anesthesia and Ropivacaine 0.2% (20 ml) was infused at each side 12, 24, 36 and 48 hours after surgery through continuous infusion catheters. Intraoperative monitoring of the patients included BIS and NOL monitors for the management of intraoperative depth of anesthesia and analgesia, respectively.

Results All patients remained stable and no complications were recorded. The mean intraoperative remifentanyl administration was 0.02 mcg/kg/min. Postoperative analgesia included paracetamol 1000 mgx4 and ropivacaine infusion from ESPB catheters. No opioids were administered to the patients postoperatively. NRS scores at several time points after surgery were <3. All patients were mobilized the day after surgery and their mean satisfaction score regarding their perioperative analgesia was 5.5 out of 6.

Conclusions ESPB performance is an innovative and simple method which can be a game-changer in improving the quality of perioperative analgesia, while it contributes in achieving enhanced recovery to patients undergoing major laparoscopic abdominal surgeries.

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CARDIOVASCULAR EFFECTS OF ADRENALINE CONTAINING LOCAL ANAESTHETICS IN ELECTIVE UPPER LIMB SURGERIES

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Background and Aims Due to paucity of information and the fact that most of the work done was related to dental work⁽¹⁾. We investigated the haemodynamic changes associated with the use of adrenaline containing local anaesthetics and whether those changes are more prominent in hypertensive patients.

Methods We carried out a service evaluation project (July 2019- July 2020) we prospectively collected data of 46 patients who underwent elective upper limb surgeries under regional blocks. Interscalene, supraclavicular and axillary blocks were used with or without midazolam sedation (doses up to 3mgs).

Exclusion criteria were patients less than 16 years old, pain or discomfort during the procedure, general anaesthesia, propofol sedation or use of beta blockers or anticholinergics.

34 patients had adrenaline containing local anaesthetics in their blocks. Eleven patients of this group had a history of hypertension.