

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.

B80 **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.

B81 **CARDIOVASCULAR EFFECTS OF ADRENALINE CONTAINING LOCAL ANAESTHETICS IN ELECTIVE UPPER LIMB SURGERIES**

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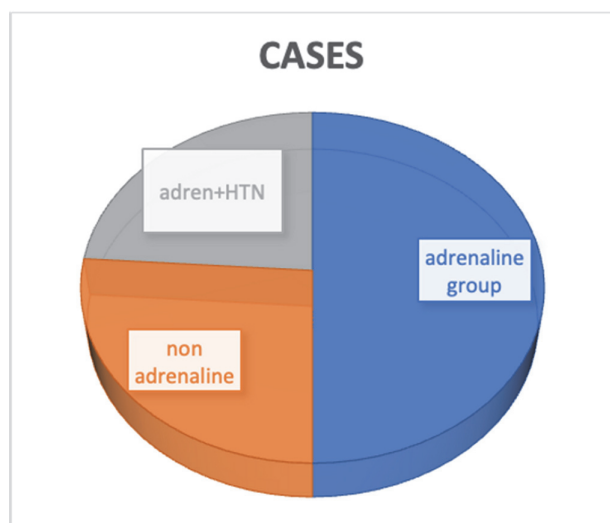
Background and Aims Due to paucity of information and the fact that most of the work done was related to dental work⁽¹⁾. We investigated the haemodynamic changes associated with the use of adrenaline containing local anaesthetics and whether those changes are more prominent in hypertensive patients.

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.

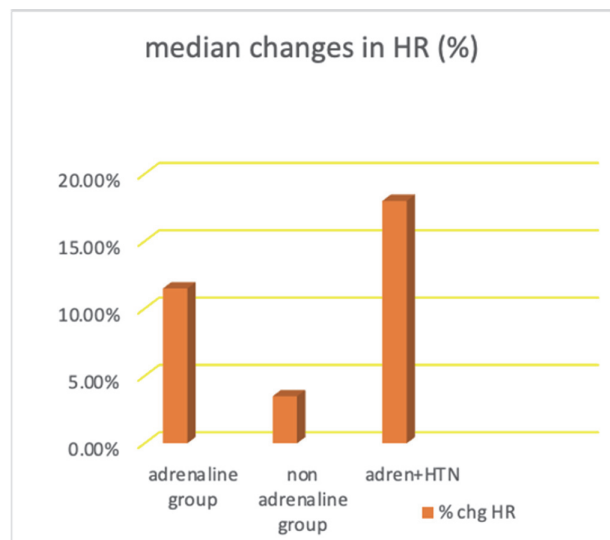
Twelve patients had their blocks with non-adrenaline containing local anaesthetics.



Abstract B81 Figure 1

Results No significant changes in systolic blood pressure in both adrenaline and non-adrenaline groups (median 1% increase in adrenaline group and 0.5% fall in non-adrenaline group)

The adrenaline group showed higher increase in heart rate (median 11.5% increase) compared to non-adrenaline group (median 3.5% increase). This effect was slightly more evident in hypertensive patients receiving adrenaline containing local anaesthetics (median 18% rise).



Abstract B81 Figure 2

Conclusions Use of adrenaline containing local anaesthetics was associated with slightly higher rise in heart rate compared to plain local anaesthetics. The rise in heart rate was more prominent in hypertensive patients. Larger studies and more

work are required to establish the clinical significance of the results.

B82 RECTUS SHEATH AND SUBCOSTAL TRANSVERSUS ABDOMINIS PLANE BLOCKS AS MAIN ANESTHETIC TECHNIQUE FOR OPEN CHOLECYSTECTOMY: A CASE REPORT

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Background and Aims Anesthesia for open cholecystectomy are traditionally either under general or neuraxial anesthesia. Fascial plane blocks are often reserved for postoperative analgesia only.¹ We report a case of an ASA Class IV patient with obstructive jaundice in severe cholangitis who underwent open cholecystectomy and T-tube drain under rectus sheath and subcostal TAP blocks.

Methods A 58-yo male patient was received in the operating room for tube cholecystostomy. He was noted to be hypotensive, hypernatremic, and drowsy. A linear transducer was placed transversely next to the umbilicus on the right where 12 ml of 0.2% ropivacaine was deposited.² Twenty-five (25) mls of 0.2% ropivacaine was deposited into the right subcostal area for the TAP block.² LA infiltration in the incision site was also done. The intraoperative cholangiogram was unremarkable however the gallbladder was emphysematous and macerated. The surgeons decided to proceed with open cholecystectomy with T-tube placement. Midazolam and fentanyl were used for sedation. Paracetamol 1g and tramadol 50mg IV were also given intraoperatively.

Results There was no complaint of pain nor wide swings in vital signs. Blood loss was at 650cc with intermittent episodes of tachycardia and hypotension which was responsive to norepinephrine. Surgery lasted 6 hours with the surgeon not noting any difficulty in retraction. The patient was fully awake thereafter.

Conclusions The use of fascial plane blocks as the sole technique in intraperitoneal anterior abdominal procedures was successful in this case. The technique may prove useful in patients who are hemodynamically unstable and have poor ASA classification scores.³

B83 MANAGEMENT OF HAND AND FOREARM FRACTURES: REGIONAL ANAESTHESIA VERSUS GENERAL ANAESTHESIA ALONE

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Background and Aims The operative fixation of hand and forearm fractures can be carried out under general anaesthesia (GA), with or without regional anaesthesia (RA) or with RA as the sole anaesthetic technique. The use of RA may provide less post-operative pain and opioid use¹. There is evidence to suggest that RA has better outcomes post-operatively in terms of range of motion and function². We sought to determine