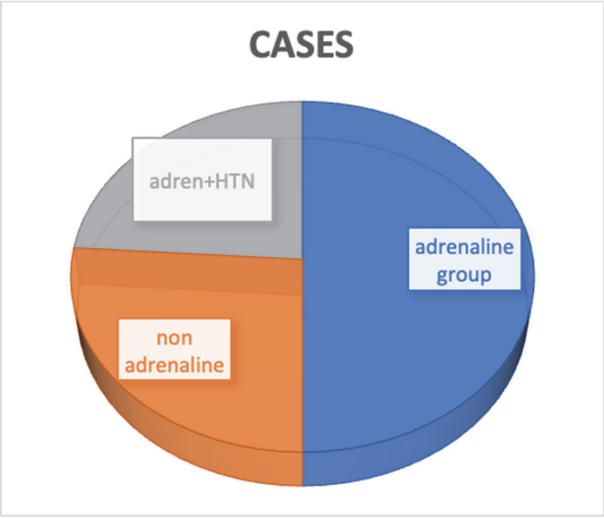
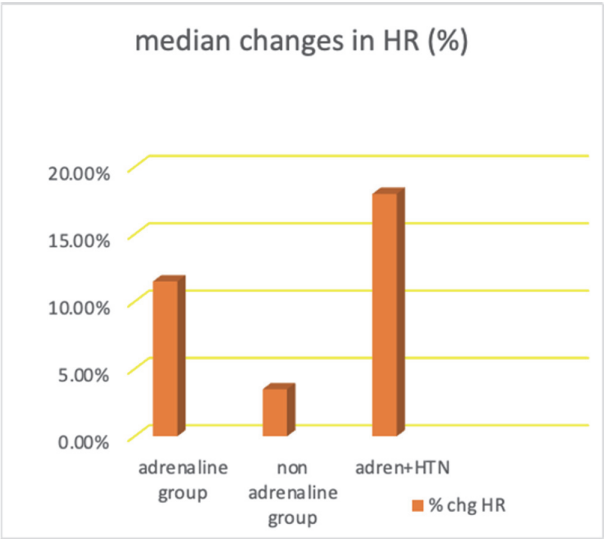
Twelve patients had their blocks with non-adrenaline containing local anaesthetics.



Abstract B81 Figure 1

Results No significant changes in systolic blood pressurein 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

JJ Arsenio*, MC Lomboy, J Remedios, JK Ramas. *Southern Philippines Medical Center, Davao City, Philippines*

10.1136/rapm-2022-ESRA.157

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

N Lal, I Thomson*. *Queen Elizabeth University Hospital, Glasgow, UK*

10.1136/rapm-2022-ESRA.158

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 use[1]. There is evidence to suggest that RA has better outcomes post-operatively in terms of range of motion and function[2]. We sought to determine

whether there were any differences in the patient experience for patients undergoing this type of surgery at our facility.

Methods All patients undergoing forearm/hand fixations between May and November 2020 at a large teaching hospital were studied retrospectively. Cases with any RA component were compared with GA-only cases. Time in recovery, time to discharge, nausea, pain scores and post-operative opioid requirements were studied. Ethical approval was not required for this study, as per our local committee.

Results 105 patients were included with results shown below. The breakdown of cases as wrist, proximal to wrist, and distal to wrist procedures were broadly similar in the RA group and GA group (78%,5%,17% vs. 89%,4%,7%) respectively. The incidence of severe pain was 3.5% (RA) vs. 41% (GA). The incidence of nausea was 2.5%(RA) vs. 9%(GA).

Abstract B83 Table 1

Values expressed as median (IQR)	RA cases (n=59)	GA only (n=46)	p value
Worst pain score in recovery unit	0 (0-0)	4.5 (0-8)	p<0.0001
Recovery opioid requirements (IV morphine equiv. in mg)	0 (0-0)	3 (0-10)	p<0.0001
Opioid requirements 1st 24 hours (IV morphine equiv. in mg)	1 (0-6)	4 (1-8)	p=0.0038
Time in recovery (mins)	0 (0-30)	37.5 (30-55)	p<0.00001
Time to discharge (hours)	16.5 (4.5-23)	22 (15.75-25)	p=0.005

Conclusions Patients who received RA only during their operative procedure experienced a better recovery profile, at least in the short-term, with better pain scores, less opioid use and a shorter recovery and hospital stay. The high incidence of severe pain in the GA only group was almost entirely abolished with the use of a RA technique.

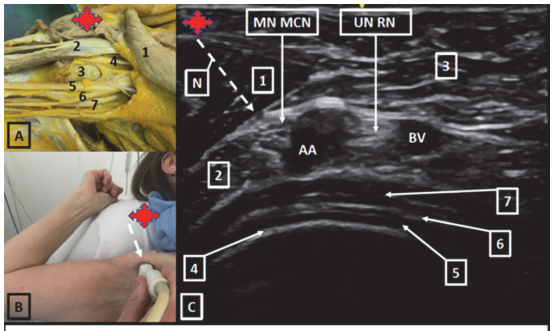
B84 BRAINE BLOCK: BRACHIAL INTERMEDIATE NERVE BLOCK

[1]A Ciorra*, [2]J-P Lecoq, [1]M Renard, [1]K Abdelkafi, [3]J-F Fils, [2]V Bonhomme, [1]E Guntz. *[1]ULB/Hôpital de Braine l'Alleud-CHIREC, Braine-l'Alleud, Belgium; [2]CHU de Liège, Liège, Belgium; [3]Ars statistica, Nivelles, Belgium*

10.1136/rapm-2022-ESRA.159

Background and Aims The aim of this study is the description of an ultrasound-guided brachial plexus blockade at the level of the head of humerus where nerves are grouped around the axillary artery

Methods Ethics committee (CHU Liège. 2017/139–140) approved this study. 20 patients scheduled for hand and forearm surgeries were blocked in supine position, the arm abducted, the elbow flexed at 90 degrees. Musculocutaneous, median, ulnar and radial nerves (MCN, MN, UN, RN) were imaged in short axis with a linear probe. A 80 mm needle was inserted in-plane, lidocaïne 1.5% with epinephrine 1:400,000 was injected. Demographic data, efficacy, block performance times, injected volumes, onset times of sensory and motor blockades, discomfort (visual analogue scale :0–10 cm), side effects were recorded. Results are expressed as mean±SD, mixed models with Turkey's multiple comparison tests were performed.



Abstract B84 Figure 1

A: 1. Pectoralis major M 2. Coracobrachialis M. 3. Head of humerus 4. Musculocutaneous N. 5. Median N. 6. Ulnar N. 7. Radial N.
B: Position of the probe on the head of humerus and part of Major Pectoralis M. Volunteer
C: 1. Pectoralis major M 2. Coracobrachialis M 3. Fat. 4. Cortical bone 5. Cartilage 6. Surface of cartilage 7. Subscapularis M. AA: Axillary artery BV: Basilic vein N: Needle

Results Complete sensory and motor blockades were obtained for 17 patients (Age: 52.75±13.48, BMI: 31.20±11.51) with 19.95±3.07 mL of lidocaine. Block performance time was 7.06±2.18 min, discomfort 2.00±1.89 cm. Onset times of sensory and motor blockades for MCN, MN, UN and RN were respectively 8.16±4.78, 8.25±4.67, 9.16±6.00, 8.82 ±4.85 min and 10.00±5.77, 11.50±5.40, 12.22±6.91, 10.29 ±5.99 min. Onset times of the 4 nerves were similar. One vascular puncture and 3 radial paresthesia occurred during blockade

Conclusions This study describes a novel and effective brachial plexus blockade technique at the level of the head of humerus where all nerves, far from the pleura, surround the axillary artery.

B85 THE FIRST USE OF LIPOSOMAL BUPIVACAINE IN A UK NHS HOSPITAL: THE FUTURE OF OPIATE-FREE SURGERY?

S Dean*, K Dasgupta, A Sathyanarayana, M Gorecha, E Mallick, D Williams. *George Eliot Hospital NHS Trust, Nuneaton, UK*

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Background and Aims The development of an opioid-free, enhanced-recovery service is the goal of many regional anaesthetists. The use of peripheral nerve blockade using traditional local anaesthetics has allowed opiate-free anaesthesia in the intra-operative period, however, patients often require opiate analgesia post-operatively with related complications[1].

We report the first use of liposomal bupivacaine (Exparel®), outside of the private sector, in a UK hospital. This allows for long-acting (>48 hrs) analgesia with minimal motor blockade after a single procedure[2].

Methods This case series looked at the first 8 patients to receive the drug undergoing elective knee replacement surgery. All patients received spinal anaesthesia containing 0.5% Heavy Bupivacaine alongside motor sparing blocks of the knee, including the Adductor canal, nerve to Vastus Medialis, Genicular nerves and interspace between popliteal artery and capsule of the knee (IPACK). They were reviewed post-