Background and Aims: Routine use of Ultrasound (US) in peripheral nerve block (PNB) has increased. Currently no International Guidelines are available for infection control measures (1). Localized inflammation is infrequent (0–13.7%), and local infection (0–3.2%), abscess formation (0–0.9%) more rarely. (2) Following the infection control guidelines and practicing strict aseptic measures result in an extremely low rate of infection following US-guided single-injection PNB. (3)

Methods: Following ethical approval from audit committee at department of anesthesiology-HGH, retrospective data of patients who received single shot PNB in the block room was collected over a period of 6 months from 1st April 2021 to 30th September 2021. Each patient was followed in person at 24 hours and through the electronic patient’s record up to 6 weeks post US guided PNB. The indication of infection was defined as occurrence of: purulent discharge, localized swelling, redness or warmth, pain or tenderness at the site of injection, or a diagnosis of infection by the surgeon or physician during this 6-week period.

Results: Total of 271 patients of which 69% are male and 31% female. Demographics are in image 1, the types of blocks performed are in Image 2. We identified 1 case of block-related redness at 24 hours and it was clear at 48 hours. Antibiotics prophylaxis in 98.2%, Cap, Mask, Sterile gloves, Sterile US prob cover and disinfectant in all patients and sterile draping in 60.5%.

Conclusions: We conclude that the incidence of infection following US guided PNBs are extremely low if we follow strict aseptic measures as per the guidelines.
Results In this case study 12 patients, 24 blocks were performed with success rate of 91.6% (n=22), requiring analgesia supplementation 8.3% (n=2), postoperative analgesia lasted for average duration for 12 hours.

No patients were converted to general anaesthesia

Conclusions The ultrasound guided spermatic cord block offers an easy, safe technique, good postoperative analgesia, avoiding complications of general anaesthesia, can be considered a better option for elderly patients minimizing the hospital stay.

Methods Patients undergoing foot surgery underwent popliteal-sciatic blocks using 10–15 ml of 2% lignocaine followed by selective ankle blocks using 10–15 ml of 0.75% ropivacaine with ultrasound guidance.

Results Surgical anaesthesia was achieved, with no requirement of additional analgesia, sedation or conversion to general anaesthesia in 100% of cases (n=19). Mean block-to-surgical-anaesthesia time was 11.89 minutes with a mean anaesthetic procedural time of 12.63 minutes. Mean volumes of 2% lignocaine and 0.75% ropivacaine used were 11.94 and 14.57 mL respectively. There were no reported instances of tourniquet or surgical pain and patient satisfaction was good. Mean surgical time was 51 minutes (range 40–75 minutes). Mean foot-drop duration was 155 minutes (range 120–210 minutes).

Conclusions This audit demonstrates that a combined regional anaesthetic technique, provides rapid onset of surgical anaesthesia for foot surgery while not being prohibitive to list efficiency. It further reveals that this is a reliable method for the reduction in the peri-operative use of sedatives and analgesic drugs while facilitating ambulatory surgery.

Background and Aims We report a case of continuous Erector spinae block for pain relief and successful weaning of patient from mechanical ventilation with multiple rib fractures

Methods After getting informed consent under all aseptic precaution and after attaching all standard monitors an erector spinae block was performed at the level of T5 transverse process using Sonosite 6–13MHz 38mm linear probe in plane technique. 18 G touhy’s needle was used and once the T5 transverse process was hit using USG guidance after negative aspiration 15 ml of 0.2% ropivacaine was given as bolus and 20G epidural catheter was inserted around 5 ml of 0.2% ropivacaine was used to hydrodissect and catheter was threaded without any resistance and the local anesthetic spread was confirmed using USG. We kept the catheter tip around 4 cm inside and the catheter was tunnelled and fixed over the skin.