Abstract B97 Figure 2

Results We reassessed the patient after half an hour and we could find his breathing pattern has improve and we could find his pain has relived. He was extubated and we formally assessed the distribution of cutaneous dermatomal block. We could find loss of cold sensation of hemithorax from T1 to T9. We also assessed the pain score at rest and after cough. Numerical pain score was 0/10 at rest and 1/10 after coughing.

Abstract B97 Figure 3

Conclusions Early pain relief in case of rib fracture will pre- vent respiratory morbidities and the regional anesthesia tech- niques play a crucial role in this regard. Continuous ESPB is a novel simple technique with less complication and rapid analgesia.

Background and Aims The erector spinae plane (ESP) block is a recent regional anaesthetic technique that can be used to provide analgesia for a variety of surgical procedures. It consists in placement of local anaesthetic between the erector spinae muscle (ESM) and the thoracic transverse processes, blocking the dorsal and ventral rami of the thoracic and abdominal spinal nerves. It has been previously used for reconstructive breast surgery, however, to our knowledge, this is the first case in which it has been used as part of a multimodal analgesic scheme.

Methods We describe a 50-year-old female, ASA II, undergoing reconstructive breast surgery with transverse rectus abdominus muscle flap under combined anaesthesia. A bilateral ESP block was performed under ultrasound guidance at the T4-T6 level in the lateral position. After visualization of the ESM and the transverse process, 20 mL of 0.5% ropivacaine were administered bilaterally, followed by induction of general anaesthesia. Surgery was completed in 4 hours and opioids were not required. Analgesia was supplemented with intravenous acetaminophen (1 g) and ceterolac (30 mg).

Results Postoperative pain relief was achieved with acetamino- phen every eight hours. Pain levels varied between 0 and 3 in the Numeric Rating Scale. Complications were not reported.

Conclusions The overall result was increased satisfaction of the patient and avoidance of opioids. Other studies are necessary to evaluate the ESP block as a valid alternative in breast surgery.

Background and Aims Kyphoplasty for vertebral compression fractures is a short but painful procedure especially during trocar insertion, balloon dilatation and cement injection. Various anesthetic techniques to control pain in elderly population are tried, but all have limitations. The following case study is to demonstrate the safety and effectiveness of a paravertebral block combined with light sedation as anesthetic method in an elderly patient with COPD.

Methods A 90 years old patient presented with a T10 verte- bra fracture and was scheduled for kyphoplasty. He also had severe COPD with an FEV1 < 30% of normal. Intraoperative monitoring consisted of ECG, NIBP and SPO2. Supplementary oxygen with a facemask 28% at 2 L/min was supplied. Induction sedation of 1 mg midazolam, 20 mg pethidine and 0.7 mg/kg/hr dexmedetomidine dosed within 10 min were given to the patient.

To promote airway safety a nasal airway No 7 was also placed.

After placing patient in a prone position we performed a paravertebral block with 10 ml of 10% ropivacaine at the fracture level under ultrasound guidance. Sedation with 0.7 mg/kg/hr dexmetomidine and 0.05 mg/kg/min remifentanil were administered during the procedure.

Results The sedation score recorded at -3, evaluated using the RASS scale. This fell under moderate sedation.
Using the VAS scale, intraoperative and postoperative pain score, recorded at 2–3 level, were minimal. Pulse rate, SpO2, and NIMB were stable intraoperatively.

**Conclusions** The case study showed that ultrasound guided paravertebral block combined with sedative analgesia is a safe and feasible method for minimally invasive treatment of vertebral fractures in elderly patients with COPD.

**B100**

**"DREAM" TUBELESS OPIATE FREE ANAESTHESIA ACHIEVED WITH PERIPHERAL NERVE BLOCKS FOR KNEE REPLACEMENT SURGERY – AN OBSERVATIONAL STUDY**

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10.1136/rapm-2022-ESRA.175

**Background and Aims** Perioperative opioids mainstay analgesia for Knee replacement surgery. Spinal opioids cause urinary retention, itchiness and vomiting. Cumulative opioid consumption causes increase CRP and fibrinogen levels - acute phase reactants.

High opiates use cause physical dependence hence we planned Tubeless opiate free anaesthesia to fulfill our DREAM ((Drink, Eat, Analgesia, Mobilise).

**Methods** Prospective Study done in 24 Patients undergoing elective Knee replacement surgery. Low dose spinal Bupivacaine heavy 0.5% 2.4 mls. No intrathecal opiates and Urinary Catheters not inserted. Adductor canal (Figure 1) at apex of femoral triangle (FT) - 15 mls Ropivacaine 0.375%. Genicular blocks - SM, SL, IL-15 mls, IPACK (Figure 2 & 3) - above condylar level - 12 mls (max total dose Ropivacaine 3mg/kg).

Intraoperative analgesia was Paracetamol, Parecoxib and Mgso4.

Tourniquet used for all.

**Results** In patients with Nerve blocks patients length of stay was reduced by 2 days. Median Motor recovery time 3 hours.

No Urinary catheter was required in opiate free group.

Opiates requirement was reduced in post operative period Tubeless "DREAM" was achieved postoperatively (No IV, Oxygen tubes & urinary catheters required).

Only patients with high Preoperative pain scores asked for further pain relief 24 hrs postoperatively & 16 patients didn’t require opiates.

**Conclusions** Opiate free Anaesthesia gives better results for enhanced recovery in post operative knee replacement patients.

Ultrasound guided Adductor canal/IPACK blocks indicated to spare intrathecal opiate and postoperative opiate requirements.

DREAM for Knee replacement patients can be realised.

Our mission was to wean patients from preoperative opioids. Our technique of RA is the mainstay in achieving that. (Ethical committee approval granted audit number 841_341 George Elliot hospital)

**B101**

**RETROSPECTIVE AUDIT ON “ULTRASOUND (US) GUIDED PERIPHERAL SINGLE SHOT NERVE BLOCK (PNB) ASSOCIATED COMPLICATIONS (NERVE INJURY) AT HAMAD GENERAL HOSPITAL (HGH) BLOCK ROOM”**

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10.1136/rapm-2022-ESRA.176

**Background and Aims** Incidences of neurological injuries after US guided peripheral nerve blocks are extremely rare, transient neurological deficits as transient paresthesia might be as high as 8–10% in immediate days and permanent nerve damage is 1.5/10,000. (1, 2, 3) The latest estimates of PNB-related temporary nerve symptoms suggest an incidence of 2.2% at 3 months, 0.8% at 6 months, and 0.2% at 1 yr. (4) The aim of this audit was to Identify the incidence of nerve injury related to single shot US guided PNBs.