

**Background and Aims** Open nephrectomy is considered leading to intense postoperative pain. A multimodal approach combining different analgesia methods with intravenous and regional anesthesia regimens to maximize effectiveness is essential and a challenge for the anesthesiologist. Erector Spinae Plane Block (ESPB) is a new technique, which is performed by depositing the local anesthetic in the fascial plane at the tip of the transverse process of the vertebra. The local anesthetic exerts its effect on the ventral and dorsal ramus of the spinal nerve. Therefore, we present a case series of 5 patients where we evaluated the effect of ESPB on postoperative pain in nephrectomy

**Methods** 5 patients were scheduled for open nephrectomy. Induction in anaesthesia was performed with Propofol 2mg/kg, Fentanyl 1mcg/kg and Rocuronium 1mg/kg. After 3 minutes of pre-oxygenation with 100% oxygen tracheal intubation was performed. Anaesthesia was maintained using desflurane 7% and 45%/55% oxygen/air mixture. All patients received 1gr Paracetamol and 0,1–0,2mg/kg morphine (iv). At the end of the surgery ESPB was performed under ultrasound guidance and 20 ml of 0,375% ropivacaine was administered at T9 level.

**Results** 5 patients ASA II-III were scheduled for open nephrectomy, mean age  $70,2 \pm 3,7$ . Mean surgical time was  $121,25 \pm 19,6$ . All patients were Hemodynamically stable and SpO<sub>2</sub> was at normal range. Mean VAS score was  $1 \pm 1,6$  the first 12h and  $3,6 \pm 1,4$  the first 24h after surgery. 2 patients received tramadol postoperative. There was no episode of postoperatively nausea or vomit.

**Conclusions** ESPB seems to be a promising analgesic technique for management of postoperative pain after open nephrectomy

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#### BEYOND THE BLOCK – AN EQUIPMENT ISSUE CAUSING BLOCK FAILURE

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**Background and Aims** We report an unusual catheter related complication that led to the failure of a continuous infraclavicular block. Informed written consent was obtained prior to writing this abstract.

**Methods** A 39 year-old lady with CRPS of the left upper limb had a Pajunk<sup>®</sup> stimulating catheter inserted and tunneled, under dual guidance, in the infraclavicular brachial plexus. The purpose of the block was to provide analgesia, in an ambulatory setting, for 3 weeks whilst the patient underwent ultrasound-guided dry needling daily. On the 13th day, patient reported unsatisfactory pain relief overnight. On examination, the entry and exit wounds were clean and the catheter remained at the 16cm mark where it had been originally placed – no dislodgement. Injection of a saline bolus revealed a spurt of fluid from the catheter, at a breakage point, generating a leak.



Abstract B104 Figure 1

The catheter was cut ahead of the break and the filter and dock reconnected. A saline bolus was re-administered to confirm the absence of any leak and Ultrasound visualization of drug spread around the brachial plexus was also seen. The dressing was reapplied and infusion of local anaesthetic mixture restarted.



Abstract B104 Figure 2

**Results** On review the next day, the patient reported good pain relief. The catheter was removed a week later without any further complications with catheter tip culture showing no growth



Abstract B104 Figure 3

**Conclusions** We surmise that the catheter wall might have been faulty and hence developed a hole in the portion secured beneath the sterile adhesive dressing (opside). We have not encountered this problem in any of our previous 42 cases

#### B105 A NOVEL REGIONAL ANAESTHETIC APPROACH TO A SENSORY KNEE BLOCK FOR KNEE REPLACEMENT SURGERY: A CASE SERIES

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**Background and Aims** Early mobilisation is key for improved outcomes following knee replacement surgery<sup>1</sup> which is limited by good analgesic control in the postoperative rehabilitation phase. A novel sensory ultrasound guided block has been proposed involving the genicular nerve (GNB), iPACK, adductor canal (ACB) and femoral nerve (FNB) to achieve optimal postoperative analgesia and mobilisation. It is our aim to determine if this modified technique reduces opioid use, time to mobilisation and length of hospital stay (LOS) compared to other methods of perioperative analgesia for patients undergoing knee replacement surgery.

**Methods** Notes were collected retrospectively following approval from the local governing body for patients undergoing

knee replacement surgery. A total of 30 notes were obtained; 16 patients with the novel sensory block (GNB, iPACK, ACB, and FNB) (*modified*); and 14 patients undergoing all other perioperative analgesic interventions (*non-modified*). Case notes were analysed and data collected regarding time to first mobilisation, opioid requirements postoperatively (morphine equivalents) and LOS.

**Results** When comparing the modified to the non-modified group; average opioid use in morphine equivalents were 81mg vs 91mg; LOS 2.6 vs 2.6 days and time to mobilisation to a standing position 6.9h vs 10.2h respectively

**Conclusions** Although a small population size, a modified novel regional block may reduce the time to mobilisation in patients following knee replacement surgery. Institutional bias including regular opioid prescriptions, limited staff availability and fixed discharge planning may account for no difference seen in opioid use and LOS.

#### B106 QUADRATUS LUMBORUM BLOCK AS SURGICAL ANESTHESIA FOR HIGH-RISK MAJOR ABDOMINAL SURGERY

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**Background and Aims** Quadratus lumborum (QL) block has been described as regional analgesia techniques in various abdominal surgeries and majority published as case reports with a few randomized controlled studies. However, current available literature described the use of QL block for postoperative analgesia to date. We present the first case report of using QL block as surgical anesthesia for a high-risk major abdominal surgery.

**Methods Case presentation:** A 29-year-old lady with underlying osteogenesis imperfecta type 3 with severe kyphoscoliosis, severe restrictive lung disease (lung function test: forced expiratory volume in 1 second, FEV1 0.36 liter; forced vital capacity, FVC 0.44 liter; FEV1/FVC 81%), cervical syringomyelia with cranio-cervical junction stenosis (C2/C3) and wheelchair bound. She has bilateral large multi-loculated ovarian cyst (CT scan showed right side: 12.1 x 9.3 x 10.3cm; left side: 6.8 x 9 x 7cm) which is significantly impairing her respiratory function. The patient and her family is keen on surgical intervention despite being informed that general anesthesia is extremely high-risk for her during the multidisciplinary meetings. She has limited anesthetic options with possibility of abandoning the surgery if unable to provide surgical anesthesia with proposed anesthetic techniques – neuraxial anesthesia as the first-choice to be supplemented with truncal block, multimodal analgesia. However, neuraxial anesthesia under ultrasound guidance and experienced hands was unsuccessfully attempted. Patient safely underwent lower midline laparotomy, ovarian cystectomy under ultrasound guided bilateral QL block with monitored sedation.