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 (opsite®). 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 \(^1\) 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. 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 LUMBO RUM 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.
Results

This is the first published case describing the use of QL block as surgical anesthesia for a high-risk abdominal surgery with multi-modal analgesia approach.

Methods A 78 year-old woman, ASA III, with CMT was scheduled for left ankle arthrodesis. A meticulous preanesthetic evaluation was carried out focusing on neurologic function.

An ultrasound guided popliteal sciatic nerve block was performed with 6 ml of ropivacaine 0.2%, followed by catheter placement (external to perineural sheath). The procedure was performed under continuous spinal anesthesia with hyperbaric bupivacaine (5mg+2.5mg).

Postoperative pain control was scheduled with 10 ml boluses of ropivacaine 0.1% on demand (lockout time of 2 hours).

Conclusions In retrospective analysis, we consider that the benefits of performing continuous perineural analgesia in our patient did not overcome the possible neurological risks, given the demyelinating nature of CMT and consequent impaired nerve conduction. Nonetheless, no complications were observed.

Background and Aims Charcot-Marie-Tooth (CMT) disease is a demyelinating, hereditary, motor and sensory neuropathy. It is the most frequent inherited peripheral neuropathy, characterized by distal muscle atrophy, weakness, and sensory loss.

While there are several reports of uneventful cases of spinal anesthesia in patients with CMT, the performance of peripheral nerve blocks in patients with preexisting neuropathy is still not consensual and current evidence is considered too sparse to allow for comprehensive recommendations regarding the best anesthetic approach.

References

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Abstract B106 Figure 1

Abstract B106 Figure 2

Abstract B107 Figure 1 Sonoanatomy of the sciatic nerve (ScN) at the popliteal fossa

Abstract B107 Figure 2 Catheter placement