Results

Abstract B106 Figure 1

Abstract B106 Figure 2

Conclusions 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.

Conclusions

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.

Methods A 78 year-old woman, ASA III, with CMT was scheduled for left ankle arthrodesis. A meticulous preanaesthetic 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).

Results In the first 48 hours following surgery, the patient required only one rescue administration of perineural analgesia, with no opioid consumption. Regular neurological examinations were performed and she was discharged without evidence of worsened motor or sensory deficits.

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.

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Background and Aims
Following success in thoracic surgery, ultrasound guided fascial plane blocks as effective analgesia for chest wall trauma have increased in popularity over the last decade due to wider patient inclusion and an enhanced safety profile.

Fascial plane local anaesthetic can be delivered by continuous infusion or intermittent boluses. Recent evidence promotes programmed intermittent boluses through a peripheral nerve catheter, with a larger volume aiding diffusion, leading to improved pain scores, reduced rescue opioid use and improved patient satisfaction.

Royal London Hospital is a MTC; between January 1st 2019 and December 1st 2021, 1119 trauma patients were treated with chest injuries. Thoracic epidural analgesia is our current standard analgesia in appropriate chest trauma patients. This requires trained anaesthetic staff, experienced nursing care post-procedure and has an accompanying low but significant complication list.

Our project objective is to implement fascial plane chest wall blocks in eligible trauma patients delivered via intermittent programmed boluses to increase the provision of effective analgesia to our trauma cohort. We will record pain scores, rescue analgesic needs and total block duration.

Methods
An electronic pump system will deliver a pre-programmed intermittent bolus of 0.125% Levobupivacaine 15 mls every 3 hours alongside a protocolised multimodal analgesic regimen.
Results We hope to demonstrate an increase in fascial plane chest wall blocks at Royal London Hospital and therefore improve our chest trauma care service with the aforementioned benefits of this technique.

Conclusions The reduction in risks associated with insertion and side effects along with minimal contraindications will undeniably transform the care of our trauma patients.

Background and Aims Visualisation and separate blockade of the four main constituent nerves (radial, median, ulnar, musculocutaneous) increases success rate of ultrasound guided Brachial plexus block at the axillary level.1,2,3,4 But upper limb is still positioned as if performing landmark-oriented approach described by Winnie with shoulder and elbow at 90 degrees (°). 4

Here, we aimed to find the optimum arm position for visualisation of brachial plexus at the axilla with ultrasound.

Methods After institutional Ethics Committee approval this observational study was conducted in 23 consenting individuals above 18 yr of age. The ultrasound probe was placed in short axis at the intersection of the pectoralis major muscle and the biceps brachii muscle with probe pressure just enough to cause light compression of veins. Each arm was placed in three different positions, shoulder at 90 ° and elbow at 90 °, shoulder at 90 ° and elbow at 0 ° and shoulder at 120 ° and elbow at 90 ° where the nerves were assessed using a six point visibility scale.

The path of each nerve was traced down for confirmation. Distance from skin to axillary artery, skin to individual nerves, artery to nerves was measured.

Results There was no significant difference in visibility scores of the individual nerves and the distances measured in the three positions except the skin -artery distance which was the least in the 120/90 position(p=0.010). The radial nerve poorly visualised in all positions.

Conclusions No single arm position improved the visibility of the nerves.

Background and Aims Thromboelastography (TEG) is a testing system designed to monitor the coagulation process in real-time. TEG-guided therapy has been shown to be valuable in a variety of invasive procedures. The utility of TEG currently has unvalidated clinical benefit in the assessment of risk in regional anaesthesia, even though it could prevent potential haematological complications such as extensive haematomas in the nerve sheath or injection site, profound motor signs and nerve damage.

The aim of this audit is to assess whether the use of TEG in assessing the risk for regional anaesthesia for lower limb amputations affects the rates of the complications.

Methods In this service evaluation audit, data from the patient information system (Powerchartâ) will be analysed retrospectively and compared with patients recruited prospectively, to whom TEG will be used to assess their coagulation potential. 30 patients from each group will be analysed focusing on a 30-day complication rate due to regional anaesthesia. All patients must have been prescribed and adhered to at least one dose of anticoagulation in the 7-day period before regional anaesthesia is performed.

Results Result will be presented with statistical analysis and their clinical effectiveness will be assessed collectively with the financial consequences on the healthcare provider. Adding TEG to standard regional anaesthesia intervention will be also assessed qualitatively according to the type and frequency of complications presenting.