received general anesthesia and a pericapsular infiltration by the surgeon.

The primary outcome was post-operative pain scores. Secondary outcomes were opioid use as morphine milligram equivalents (MME) during the post anesthesia care unit (PACU) period, PACU recovery time, and adverse events.

**Results**
There was no significant difference in terms of demographics and preoperative pain scores.

PACU pain scores and worst and average pain over 7 post-operative days were not significantly different.

Less intraoperative opioid was administered in the QL block group when compared to the control group (16.82 ± 7.87 vs. 20.59 ± 97.99 MME; p = 0.0055). However, PACU opioid consumption was similar between groups. Phase 1 PACU duration was shorter in the control group (58.98 ± 23.35 vs. 73.17 min ± 43.98; p < 0.01), but there was no significant difference in total PACU time. There was no significant difference in adverse events.

**Conclusions**
There seems to be no benefit associated with the administration of a QL block in addition to pericapsular infiltration for patients undergoing hip arthroscopy.

Of note, in our study, all patients received pericapsular infiltration. This might explain differences with other studies.

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**B120**
**AN AUDIT OF PATIENT SATISFACTION AFTER REGIONAL ANAESTHESIA IN A TERTIARY CENTRE**

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**Background and Aims**
Peripheral Nerve Blockade (PNB) has been associated with improved analgesia outcomes compared to opioid analgesia, with the added benefit of avoiding opioid-related side-effects. Few studies have investigated patient satisfaction with PNB, which is an important indicator of quality of care.

**Methods**
A consecutive sample of patients who underwent surgery under regional anaesthesia were identified through theatre records.

Patients were contacted by phone shortly after discharge. They were asked to complete a telephone survey which featured questions regarding, perceptions, expectations, analgesic effects, adverse effects, overall satisfaction and their willingness to undergo PNB again should it be needed. 5-point Likert charts were used to gauge satisfaction. Severity of pain was reported on a numerical scale.

**Results**
26 consecutive patients who underwent surgery with PNB were identified from theatre records. 15 were successfully contacted and consented to be surveyed. 14 patients had a brachial plexus block using the axillary approach for ORIF of the radius (n=10). Patients reported a high degree of satisfaction with regional anaesthesia (see figure 1), few side-effects and a good analgesic effect.

**Conclusions**
Our survey results suggest that patients report a high rate of subjective satisfaction when undergoing PNB as well as experiencing good intraoperative analgesic effect. The rate of adverse effects was limited. These results suggest that PNB is well tolerated and warrants consideration when planning the anaesthetic approach to certain cases, in particular the use of a brachial plexus block suing the axillary approach for ORIF of the radius.

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**B121**
**CLAVICEPTORAL FASCIA BLOCK FOR CLAVICULAR FRACTURE SURGERY IN A HIGH-RISK PATIENT – A CASE REPORT**

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**Background and Aims**
The complex innervation of the clavicle makes it challenging to achieve a complete nerve block for clavicular surgery; the medial part being most arduous. We present a case of a successful clavicular repair in a high-risk patient, performed entirely in peripheral nerve blocks. A 54-year old male, active smoker, involved in a motorcycle accident 7 days earlier, suffered a fractured clavicle and scapula, flail chest with costa 2–9 fractures, haemo-pneumothorax as well as lung contusions/lacerations – all to his right side. The clavicle was spirally fractured, extending from and through the shaft to medial part. Injuries were initially treated with drainage and additional oxygen therapy. The chest drain was inadvertently removed a few days prior to surgery, leaving minimal pneumothorax. Considering the patient’s condition and medical background, we aimed to avoid mechanical ventilation as well as preserving the function of the diaphragm throughout the perioperative period. To achieve set goals, we chose a claviceptoral fascia block combined with a block of the supraclavicular nerve.
Methods We performed an ultrasound-guided clavipectoral fascia block, using 30 ml Ropivacaine 5mg/ml. A supplementary superficial cervical plexus block with 8 ml Ropivacaine 5mg/ml was performed due to unreliably detecting the supraclavicular nerve.

Results No additional intraoperative analgesia was required. Full diaphragmic function was asserted by ultrasound post-surgery, and post-operative care was uneventful with sufficient analgesia.

Conclusions A clavipectoral fascia block may be a good alternative to general anesthesia and other regional anesthesia techniques for clavicular surgery in high-risk patients.