with clear instructions regarding management and escalation pathways is required.

B136 QUADRATUS LUMBOrium BLOCK FOR POSTOPERATIVE ANALGESIA AFTER CAESAREAN SECTION
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Background and Aims Pain after cesarean section (CS) has a somatic and a visceral component. Insufficient pain control in the postoperative period compromises recovery and increases the risk of developing chronic pain. The quadratus lumborum block (QL) is a fascial plane block with a potential capability to provide visceral and somatosensory analgesia. This effect is probably due to the spread of the local anesthetic beyond the transversus abdominis plane into the paravertebral space.

The aim of this study was to compare the analgesic efficacy of QL block with the transversus abdominis plane (TAP) and the ilioinguinal-iliohypogastric (IL-IH) blocks in women undergoing CS.

Methods A retrospective study was performed including women from 2015 to 2022 who underwent spinal anesthesia for CS combined with QL, TAP or IL-IH blocks for postoperative analgesia. The effectiveness of QL, TAP and IL-IH blocks was compared by using pain scores and requirement of rescue analgesia. This work was approved by the ethic committee.

Results A total of 255 women were enrolled for this study. At 24 hours after surgery, at rest, 97% of women experienced no pain or mild pain and 3% moderate pain. In movement, 75% presented no pain or mild pain, 21% moderate pain and 4% severe pain. Comparing the different blocks performed, no differences were found.

Conclusions Nerve block techniques as part of a multimodal analgesia strategy is associated with reduced pain scores in parturients undergoing CS. The results of this work suggest that QL, TAP and IL-IH blocks provide comparable postoperative analgesia.

B137 WHEN GENERAL ANESTHESIA ISN’T PLAN A – CASE REPORT IN A PATIENT WITH IDIOPATHIC CARDIOMYOPATHY
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10.1136/rapm-2022-ESRA.212

Background and Aims Cardiac disease represents a challenge to anesthetists, particularly pathologies associated with low ejection fraction. Anesthetic management should focus on preventing intraoperative hypotension and increases in afterload and heart rate, while maintaining adequate levels of anesthesia. Central neuraxial blockade reduces afterload and improves cardiac output but is associated with hypotension. Regional anesthesia is associated with minimal hemodynamic changes while reducing pain and its side effects, namely increased myocardial work and oxygen demand, tachycardia and systemic vascular resistance.

Methods 43 years-old man, scheduled for femoral nailing and tibial osteosynthesis. Past history of idiopathic cardiomyopathy and a diagnosed ejection fraction of 23%, implanted CRT-D, and on the waiting list for a heart transplant. The defibrillating function was disabled preoperatively. Ultrasound guided femoral, obturator and sciatic nerve blocks were performed using ropivacaine 0.375%. A selective spinal block was performed with 5 mg of bupivacaine.

Results The patient was stable intraoperatively and then admitted to ICU for 24 hours, with an uneventful postoperative recovery. Reported pain management was satisfactory.

Conclusions A patient-centered, individualized anesthetic plan must consider patients’ comorbidities. Regional anesthesia plays an essential role in the management of patients with cardiovascular disease, as part of the analgesic plan and as a safer alternative to general anesthesia, avoiding its well-reported side effects. Peripheral nerve blocks can be used together with selective neuraxial blockade, reducing local anesthetic doses and sympathetic blockade.

B138 EFFICACY OF BUPRENORPHINE AS ADJUVANT IN PERIPHERAL NERVE BLOCKS DURING TOTAL JOINT ARTHROPLASTY: A NARRATIVE REVIEW AND SYNTHESIS OF THE EVIDENCE
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10.1136/rapm-2022-ESRA.213

Background and Aims The duration of peripheral nerve block (PNB) is of critical importance in the pain trajectories of total joint arthroplasties (TJA). Rebound pain increases opioid consumption and worsens the patient’s functional outcome.1 Continuous PNBs have a failure rate of 20% to 50% and they are associated with complications such as systemic local anesthetic toxicity, local infection, nerve irritation, and an increased risk of postoperative falls.2 Among the alternatives studied to improve PNB analgesia, buprenorphine, a partial μ-opioid receptor agonist and weak κ-opioid receptor antagonist, has a good efficacy and safety profile.3 The objective of this narrative review is to summarize the evidence about buprenorphine as perineural adjuvant to prolong analgesia after TJA.

Methods Approval from the ethical committee was not necessary for this narrative review. Two independent reviewers searched several databases (Pubmed, Embase) for articles related to the use in TJA (hip, knee, shoulder) of buprenorphine as a perineural adjuvant in PNB with or without other adjuvant molecules. Articles included were those published through March 2022 and in English.

Results 5 randomized clinical trials (RCT) were identified (Table 1). 3 trials for TKA, 1 for TSA and 1 trial for both THA and TKA. In all these 5 RCT, buprenorphine is used perineurally with local anesthetics in nerve blocks.Perineural buprenorphine alone or in combination with other adjuvants globally improve postoperative analgesia without increasing side effects such as postoperative nausea.
Conclusions

**Buprenorphine** is effective in improving analgesia during TJAs. However, the evidence is still weak and further trials on this topic are needed.

**B139**

**PREP, STOP & BLOCK**

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**Background and Aims**

To audit on the change of protocol for Peripheral nerve blocks (PNBs) to avoid inadvertent wrong sided block in a tertiary hospital of Dublin. This audit is based on modified version of traditional “Stop before you block” protocol introduced in 2021.

**Methods**

This audit was based on questionnaires given to each Operation theatre anaesthesia room for the nurses and doctors to fill out after PNBs. The duration of audit was of 1 month from 4th March 2022 to 4th April 2022. All patients records were reviewed for proper recordings in pre designed structured form.

**Results**

In this duration, total 52 PNBs were done while only 38 forms were filled for audit. Among these 38 blocks, 30 blocks (79.8%) were for lower limbs, 6 (15.7%) for upper limbs and 2 (5.2%) for abdominal procedures. The Prep (preparation) of drugs, equipments and area was done 100% as per hospital policy. However, Stop was done “verbally” only for 15 (39.4%) blocks. But “mark” was checked in 36 (94.7%) blocks. Finally, Block was given immediately in 37 (97.3%) blocks and it was delayed in 1 (2.6%) block but Prep, stop was not repeated for that block.

**Conclusions**

Conducting an audit on Prep, stop and block protocols is essential for every hospital in which peripheral nerve blocks are done. It avoids the inadvertent wrong sided block which is a “never event”. The above audit clearly shows room for improvement.

**B140**

**IMPLEMENTING A STANDARDISED TECHNIQUE FOR ADDUCTOR CANAL BLOCKADE FOR UNICOMPARTMENTAL KNEE REPLACEMENT IN A TERTIARY ORTHOPAEDIC CENTRE**

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**Background and Aims**

The ideal regional anaesthetic technique for unicompartmental knee replacement (UKR) should provide good analgesia without compromising patient ability to mobilise post-operatively. Various approaches to blockade site and volume have been considered. Low volume ACB should avoid motor blockade of medial vastus nerve and inadvertent proximal local anaesthetic spread and quadriceps weakness. In our tertiary orthopaedic centre a standard operating procedure (SOP) was created advising low volume, low concentration adductor canal blockade (ACB) of the saphenous nerve with 10 ml 0.2% ropivacaine, alongside effective surgical local infiltration.

**Methods**

This ethics-approved prospective audit reviewed records of around 30 consecutive patients undergoing UKR, and assessed whether ACB was performed, dose and volume of local anaesthetic used, and 24-hour post-operative opiate consumption. Two cycles were performed; one pre-SOP introduction, one six months post-introduction. For comparison, data were grouped as ‘compliant with recipe,’ ‘non-compliant’ or ‘no ACB performed.’

**Results**

Pre-SOP, a total of 17 different ACB recipes were utilised, with large variations in post-operative opiate consumption. Re-audit showed utilisation of ACB in 70% of cases, and 57% compliance with SOP when ACB was performed. Post-operative opiate consumption decreased when ACB was compliant versus non-compliance, from 40.4mg to 22.5mg oral morphine equivalence. When ACB was not used, opiate consumption was markedly higher at 76mg.