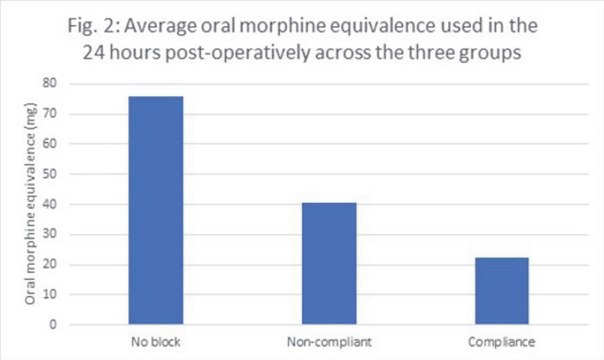

Abstract B140 Figure 2

Conclusions Appropriately sited low volume, low concentration ACB can improve patient experience post-UKR. Introduction of a local SOP in such patients has shown good clinician uptake in addition to reduced post-operative analgesia use. Further targeted clinician education will now aim to improve performance and patient outcomes.

B141 PROCESS IMPROVEMENT FOR AMBULATORY UPPER LIMB SOFT TISSUE TRAUMA SURGERY

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Background and Aims Regional anaesthesia (RA) is ideally suited to upper limb soft tissue trauma surgery (ULSTTS). Compared to general anaesthesia (GA), RA confers several benefits including: better analgesia; less postoperative nausea and vomiting; early independent ambulation; early hospital discharge and high patient satisfaction. The deliberate design of a ULSTTS patient pathway to incorporate RA may confer additional institutional benefits. We developed a RA based ULSTTS pathway and measured the influence on operating theatre time and cost.

Methods Baseline control theatre time data were gathered from theatre records from September and October 2020. Prospective data were collected from April to December 2021. A bottom up cost comparison data analysis for drugs and consumables used was performed. One hundred patients were followed-up by telephone at 24 hours for evaluation of pain (verbal rating score 0–10) and satisfaction (verbal rating score 0–5).

Results From April 2021 to December 2021, we performed 238 ULSTTS surgeries under RA. When compared to matched GA controls, RA patients consumed 26 minutes less total operating theatre time per case. The median per case cost of drugs and consumables for ULSTTS using GA and RA were € 227 and € 20 respectively. The estimated time and cost saving attributable to RA during the study period was calculated as 6188 minutes (103 hours) and € 49,266. At 24 hour followup the median [range] pain and satisfaction scores were 1 [0–5] and 5 [3–5] respectively.

Conclusions RA for ULSTTS is both feasible and effective within a bespoke patient pathway. Significant patient and institutional benefits can be derived

B142 ULTRASOUND-GUIDED ERECTOR SPINAE PLANE BLOCK IN CORONARY ARTERY BYPASS SURGERY: THE ROLE OF LOCAL ANESTHETIC VOLUME – A PROSPECTIVE, RANDOMIZED STUDY

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Background and Aims Although the effectiveness of erector spinae plane block (ESPB) in cardiac surgery has been shown [1], but the optimal volume of ESPB in CABG surgery remains unclear. We hypothesized that using larger volumes of local anesthetic in the ESPB would result in greater dermatomal blockade. The aim of this study is to determine the analgesic efficacy of ESP block with two different volumes in CABG patients.

Methods This prospective,randomized study was conducted in adult patients undergoing CABG surgery with cardiopulmonary bypass. Group-20 received 20 ml of 0.25% bupivacaine perside in ESPB and Group-30, 30 ml of 0.25% bupivacaine perside. Following extubation, tramadol 100mg as rescue analgesia was given to patients of NRS>4. Postoperative sternotomy and chest tube pain was evaluated using the NRS at rest and during coughing after extubation.

Results 70 patients were analyzed. There were significant differences between the groups regarding rescue analgesic was higher in the group 20 ml (25/35vs2/35,$p<0.001$) and the time of the first rescue analgesic requirement. The mean time ±std were 11.26±9.57 hours and 24.03±4.12 hours in the group 20 ml and the group 30 ml,($p<0.001$). The median-(IQR) NRS scores, both at sternotomy and chest tubes, were significantly lower in the group 30 ml at the different time points after the surgery ($p<0.05$).

Conclusions The ESP block performed with a volume of 30 ml, less pain was observed in the sternum and chest tube region, less rescue analgesic requirement, and late first rescue analgesic requirement time. 30 ml can be effective in chest tube and sternum pain in cardiac surgery.

B143 ESP BLOCK AS A PART OF OPIOD FREE ANESTHESIA IN OPEN SPINE FUSION SURGERY CASE SERIES

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Background and Aims Multimodal analgesia in open spinal fixation surgery allows use of less opiates peroperatively and better patients' outcome [1]. Erector spine block significantly reduces peroperative use of opiates during these operations[2]. Non-opioid anesthesia supplemented with ESP block provides good peroperative analgesia and avoids opioid administration during surgery and postoperatively[3].

Methods We will describe a series of 10 patients planned for open spine fixation on one or more levels.Before induction in anesthesia, each patient received 1.0 g of Paracetamol.The induction to general anesthesia was with 1 mg/kg Lidocaine,