and posterior chest wall and also lower cervical roots, when performed at a high thoracic level (1,2,3).

**Methods** We present the case of a 64 years old male with a sarcoma of the left shoulder with scapular invasion, proposed for scapulectomy. After the surgery, under general anesthesia, the ESPB was performed at T3 level with 20 mL of 0.25% levobupivacaine followed by catheter placement. No pain or complications were in the immediate postoperative period as well as in the next days, reciving 20 ml mandatory bolus of 0.2% ropivacaine every 4h and 1g of acetaminophen every 8h.

**Results** Considering our literature review, this is the first case described with the application of ESPB for post-scapulectomy pain control. We choose the T3 level in an attempt to achieve a C5-T5 cranio-caudal dispersion. Given the possibility that the uppermost dermatomes were not reached, the infiltration of the brachial plexus exposed by the surgical incision and superficial cervical block were also performed. With this technique, a pain and complication free postoperative period was achieved.

**Conclusions** Being an anatomically easy and safe block to perform with ultrasound support, we consider that it could become the first option in regional analgesia for scapulectomy.

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**Abstract B189 Figure 1**

Conclusions There is insufficient experience and evidence to suggest which intrathecal systems achieve best results1, nevertheless, lower gauge spinal needles may be alternatives when difficulties are encountered with technique performance.

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**B190** **PERIPHERAL NERVE BLOCKS IN ABOVE THE KNEE AMPUTATION: CAN THEY BE THE ONLY ANESTHETIC TECHNIQUE USED?**

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**Background and Aims** Above knee amputation (AKA) is associated with considerable mortality and morbidity. There is paucity of data describing the use of peripheral nerve blocks (PNB) as the sole anaesthetic technique in patients undergoing AKA.

**Methods** A 65 years old man (weight 60kg) diagnosed with diabetic ketoacidosis was found in cardiac arrest short after admission. Advanced life support was successfully performed. His medical history was significant for ischemic heart disease, heart failure, peripheral artery disease, chronic kidney disease and had an implantable defibrillator. A two-dimensional echocardiogram showed a 10% left ventricular ejection fraction. He was then transferred to the Intensive Care Unit. During his stay an acute limb ischemia was diagnosed. Unfractionated heparin was started, and he was proposed for a life-saving AKA. He presented to the operating room with non-invasive ventilation and vasopressor support. We performed echocardioguided subgluteal sciatic, obturator and femoral nerve blocks with 0.5% ropivacaine. Supplemental sedation with dexmedetomidine was used. The surgical procedure was uneventful and the patient remained hemodynamically stable.

**Results** We were left with few anaesthetic options. General anesthesia was too risky in such an unstable patient. Subarachnoid block was contraindicated. We ended up performing regional blocks as the sole anaesthetic technique.

**Conclusions** Although challenging and sometimes requiring supplemental sedation PNB can be a viable option for AKA in high-risk patients.