operatively, and the appropriate use of regional anaesthesia to provide the safest care for our patient.

B242 BILATERAL ERECTOR SPINAE PLANE BLOCK AND CATHETER PLACEMENT FOR PAIN RELIEF IN A PATIENT WITH MULTIPLE RIB FRACTURE

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Background and Aims Erector spinae plane block is a relatively novel approach to pain management for a variety of surgical procedures, as well as for acute and chronic pain[1]. It is performed as a single injection block, or a catheter is placed for continued relief, and the procedure is most often performed with ultrasound guidance. Multiple rib fracture requires early intervention with adequate pain relief to prevent potential chest infection and prolonged hospital stay and, regional anaesthetic techniques are often a crucial component in analgesia.

Methods A 41-year-old female was admitted through A&E with Bilateral multiple rib fractures. The patient was trampled by a cow and sustained multiple injuries. Her CT scan reported clear lungs, with no pneumothorax or haemothorax. There were displaced rib fractures on the right side namely anterior 2nd and 3rd, antero-lateral 6th, postero-lateral 8th and 11th. Displaced rib fractures on the right side were anterior 3–6th ribs and postero-lateral 12th rib. Apart from this left clavicle fracture was fractured on medial one-third, T12 - L2 spinous process fracture, T12-L4 right transverse process fractures with significant displacement. Additionally, comminuted nasal bone fractures were reported. Bilateral erector spinae block and placement of catheter was performed under ultrasound guidance.

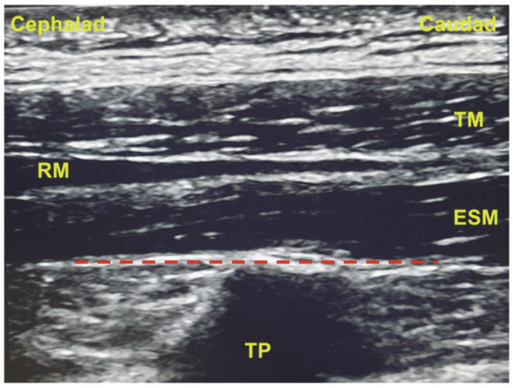
Results

Abstract B242 Table 1

VAS score in 48 hrs after the erector spinae block and catheter placement

Hours after Block	VAS score	Rescue analgesia	Complication
2	2		None
3	3		None
4	2		None
6	3		None
8	4		None
16	6	PCM+ OM	Drowsy
24	5	PCM	None
32	5	PCM	None
40	4	PCM	None
48	3	PCM	None

Fig. 1: Sonoanatomy for erector spinae plane block



TM: trapezius muscle, RM: rhomboid muscle, ESM: erector spinae muscle, TP: transverse process of the 4th thoracic vertebra. Dashed red line: erector spinae plane
Probe placed in sagittal plane approximately 3cm lateral to the midline. More lateral placement will reveal thoracic ribs with pleura beneath.

Abstract B242 Figure 1

PCM- Paracetamol OM- Oramorph

Conclusions Chest wall injuries are associated with significant morbidity and mortality, especially in patients with coexisting respiratory disease[2]. Thoracic epidural, thoracic paravertebral, and intercostal blocks are available for the pain relief options, each has unique advantages and disadvantages. In our institution Erecter spinae block and catheters are offered along with other options.

B243 REGIONAL ANESTHESIA ROLE DURING LIMITATION OF LIFE SUSTAINING MEASURES – A CASE REPORT

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Background and Aims Ethical dilemmas regarding the limits of perioperative medical interventions are growing concern in clinical practice. Increasing age and associated comorbidities along with anesthetic-surgical advances presents challenges when considering questions as "whether to operate or not?" or "how to impact minimally in fragile homeostasis?".

Methods Our case report describes an 86-years-old man (Clinical Frailty Scale score 5) proposed to an emergent drainage of an intramuscular gastrocnemius abscess. Beyond their significant comorbidities (peripheral artery disease, ischemic cardiomyopathy) he was in septic shock with multiple-organ dysfunction (serum lactate 8.8 mmol/L). Intensive Care Unit (ICU) based-resuscitation team approached the patient in the ward and established a limitation of life-sustaining measures with refusal to be admitted in the ICU. However, in an expanded multidisciplinary team-meeting with Anesthesiology and Orthopedics, it was decided to operate under regional anesthesia (RA): sciatic nerve block with a popliteal approach.

Results The anesthetic cover of the surgical field allowed the source control. Thereafter, it was decided to implement fluid resuscitation and a vasopressor (noradrenaline 0.5 mcg/kg/min). The patient exhibited a favorable clinical-laboratory response leading to a reassessment of the ICU admission