Background and Aims Analgesia in regional thigh is frequently performed through femoral nerve and lateral femoral-cutaneous blockade. Thigh proximal lateral region is innervated by the iliohypogastric nerve and T12. The ultrasound-guided suprailiac crest (SIC) block is a novel technique useful to provide analgesia.

A woman 76 years old, with a significant medical history which included autoimmune-thrombocytopenia and cardiovascular diseases, was firstly treated by gamma-nailing due to per trochanteric fracture. Subsequently she was diagnosed with purulent dehiscence of the surgical wound. Since patient’s condition, we avoided general or spinal anesthesia and performed ultrasound-guided SIC block.

Methods With the patient in supine position, a linear transducer is placed over the superior-anterior iliac spine, transducer is tilted in the sagittal plane and moved laterally along the iliac crest passing through the greater trochanter. After identified the insertion of transversus abdominis, internal and external oblique muscles at the iliac crest and the planes between them, probe is tilted 90° above the iliac crest he and needle is inserted in plane anterior to posterior to reach the fascia between the two oblique muscles. Associated to the femoral cutaneous nerve block, a full skin’s anesthesia in the superior lateral thigh region, from the iliac crest to the proximal third of the thigh, was obtained.

Results Surgery was conducted under sedation and locoregional anesthesia, no intraoperative pain was referred.

Conclusions SIC block provides an analgesic and specific anesthesia in the area left uncovered by the others nerve blocks. This could be an easy and safe technique, avoiding the use of other pharmacological strategies.
Conclusions The use of new anesthetic agents and different formulations may be risky. We must always have a high level of suspicion and be prompt for any kind of complication.

**METHODS**

A 48 years-old man, ASA II, was scheduled for posterior arthrodesis from L-3 to the ileum due to sacral fracture. The patient suffered from hypertension, dyslipidemia and diabetes. His laboratory examinations showed no significant alterations.

**RESULTS**

Sacral erector spiniae plane block (ESPB) was planned for postoperative analgesia as a part of multimodal analgesia (Paracetamol 1g, Ketorolac 30mg and Ketamine 30mg). Following standard anesthesia induction, the patient was placed in the prone position. Sacral ESPB was applied under general anesthesia. With a high frequency linear transducer placed parallel to the median sacral crest we visualised the S1 intermediate sacral crest. With a caudal to cranial in-plane approach we injected 20 mL of ropivacaine 0.20% between the erector spiniae muscles and intermediate sacral crest, bilaterally. We noticed the rising up of the muscle above the bone resulting in a caudo-cranial spread of the drug. After the surgery, patient was extubated and transferred to the recovery room. He reported 3/10 NRS immediately after surgery, with no need of rescue medication.

Conclusions Sacral ESP block can be a useful and safe technique, as a part of multimodal analgesia, to markedly reduce pain in sacral arthrodesis.