of Regional Anesthesia and Pain Medicine (ASRA) and the European Society of Regional Anaesthesia and Pain Therapy (ESRA) to release a joint statement on anesthesia use (1). Their statement included a recommendation to use regional anesthesia whenever possible to mitigate the risk associated with aerosolizing procedures. We sought to examine the utilization of anesthesia in pediatric patients undergoing a surgical procedure for fracture or ligament repair before and during COVID-19.

Methods This study is approved by Hospital for Special Surgery Institutional Review Board (IRB# 2016–436). We used the Premier Healthcare Database to identify pediatric patients undergoing a surgical intervention for fractures or ligament repair before COVID-19 (March-June 2019) and during (March-June 2020). We compared general, regional, and combined general-regional use before and during COVID-19.

Results We identified 6,415 patients undergoing a surgical procedure for fracture or ligament repair before and during COVID-19. After exclusions for unknown anesthesia use, 3,052 patients were included in our cohort with 82.9% (n=2,530) of patients undergoing a procedure under general anesthesia, 6.0% (n=182) under regional anesthesia, and 11.1% (n=340) under combined general-regional anesthesia. There was no difference in the type of anesthesia used before and during COVID-19 (p=0.053, Table 1).

Conclusions We did not find a significant difference in anesthesia use before and during COVID-19 among pediatric patients undergoing a surgical procedure. The significance of these findings highlights how societal recommendations and historical precedent may not influence pediatric anesthesia practice models.

**Does neurostimulation improve efficacy for ultrasound-guided trans-perineal pudendal nerve block in children? A randomised controlled trial**

A 5-months-old, 4kg, with VACTERL, presents for Nissen fundoplication and gastrostomy. During her 180-day hospital stay she underwent primary esophageal atresia repair, colostomy, tracheostomy, had multiple respiratory complications, three mechanical ventilation cycles, and received long-term opioid therapy showing withdrawal symptoms after discontinuation.

After anesthesia induction, surgery started laparoscopically but due to patient’s intolerance to pneumoperitoneum was converted to a midline laparotomy. Intraoperatively, IV fentanyl 10mcg, paracetamol 60mg and morphine 0.2mg were administered. Endmost, ultrasound-guided bilateral T7-T8 single shot ESPB (3+3 ml ropivacaine 0.15%) was performed. For postoperative pain management we elected IV paracetamol 60mg 6/6h and rescue morphine.

**Results** Patient was extubated uneventfully.

Based on comfort level, stable vital signs, limited oxygen requirement and absent need for rescue medication, she was safely discharged to the ward, obviating the need for ICU.

FLACC score was used to assess pain at 0–3–6–18 hours and was 0–3/10 over time.

No rescue opioid was administered. Parents were satisfied and no postoperative complications were observed.

**Conclusions** ESPB appears to be useful for pain management purposes in upper abdominal surgeries in pediatric patients with pulmonary impairment and pain treatment concerns, with optimal safety profile and sensitive coverage.