of local anaesthetic used, and 24-hour post-operative opiate consumption. Two cycles were performed; one pre-SOP introduction, one six months post-introduction. For comparison, data were grouped as 'compliant with recipe,' 'non-compliant' or 'no ACB performed.'

Results Pre-SOP, a total of 17 different ACB recipes were utilised, with large variations in post-operative opiate consumption. Re-audit showed utilisation of ACB in 70% of cases, and 57% compliance with SOP when ACB was performed. Post-operative opiate consumption decreased when ACB was compliant versus non-compliance, from 40.4mg to 22.5mg oral morphine equivalence. When ACB was not used, opiate consumption was markedly higher at 76mg.

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.

Background and Aims A 50 year-old male, ASA II has had suffered high energy blunt thoracic trauma from a road traffic accident presented with left-sided thoracic and upper limb trauma. On presentation had mild respiratory distress despite being hemaodynamically stable and an oxygen saturation of 93% on room air. Head and cervical spine were negative. Thoracic scan showed displaced rib fractures 1st to 7th and concomitant ipsilateral severe lung contusion, fractured clavula, clavicle and three thoracic vertebrae. Patient required fixation of four ribs and his elbow. Neighter the vertebrae, nor the clavicular and scapular fractures needed operative treatment.

Methods In order to facilitate extubation and physiotherapy a superficial serratus anterior catheter were placed under ultrasound guidance and once loaded with 20 mL bupivacain 0.25% patient succesfully extubated on high-flow nasal
cannula oxygen with 0/10 chest pain at rest. The severe pain around the clavicle and scapula managed effectively with a superior trunk catheter of the brachial plexus instead of interscalene to spare the phrenic nerve. Bolusing with 6 mL of Lidocain 1% provided complete analgesia with intact diaphragmatic movement on ultrasound. Continuous blocks were accomplished by intermittent boluses in every 12 hours instead of infusion in order to facilitate mobilization.

Abstract LB7 Figure 2

Results The effectiveness of the intermittent blocks judged by low pain scores and superb respiratory function.

Conclusions Sublatisinus serratus catheter proved efficient pain relieve after thoracic surgery. Superior trunk catheter and low volume LA covers clavicle and scapula while preserving diaphragmatic function.

Background and Aims Open cholecystectomy is a frequently performed procedure for symptomatic cholelithiasis in Sub-Saharan Africa due to lack of laparoscopic equipment or expertise. Although it has traditionally been performed under general anaesthesia in the developed world, general anaesthesia safety and access are particularly affected by resource gaps encountered in underdeveloped countries. Therefore, neuraxial anaesthesia is increasingly considered a safe, effective, and less resource-intensive option in low-resource countries.

Methods The authors describe the successful use of neuraxial anaesthesia in a 48-year-old female patient proposed for urgent open cholecystectomy during a medical-humanitarian mission at the Simão Mendes National Hospital in Guinea-Bissau. Considering the local resource gaps, namely lack of access to functioning anaesthetic machines, basic airway equipment, capnography, neuromuscular function monitors, and even oxygen cylinders, regional anaesthesia was preferred rather than general anaesthesia. After informed consent, a combined spinal-epidural anaesthesia was performed using a separate needle technique with an initial subarachnoid injection of 3 mL of 0.5% levobupivacaine and 2.5 μg of sufentanil (T12-L1 level) followed by placement of an epidural catheter (T8-T9 level) for potentially prolonged surgery and postoperative multimodal analgesia. Ketamine and midazolam were given perioperatively for analgesia and anxiolysis, respectively. The patient remained conscious, on spontaneous ventilation, without the need for supplemental oxygen therapy or vasopressors.

Conclusions Neuraxial anaesthesia may be a safe, effective, and less expensive approach for urgent open cholecystectomy in Sub-Saharan Africa patients under similar circumstances.

Abstract LB8 Figure 2

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 controlled 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 follow-up 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.