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.

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

**Conclusions** Sublatisimus serratus catheter proved efficient pain relief 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-intense 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, cannography, 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.

**Results** General anaesthesia was successfully avoided. The procedure was uneventful and postoperative recovery was unremarkable, with the patient being discharged within 24 hours.

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

**Abstracts**

**LB9** PROCESS IMPROVEMENT FOR AMBULATORY UPPER LIMB SOFT TISSUE TRAUMA SURGERY

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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 control 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.