

LB12

INTERVENTIONAL TREATMENT OF CHRONIC PAIN IN PATIENT AFTER THORACOTOMY APPROACH CASE REPORT

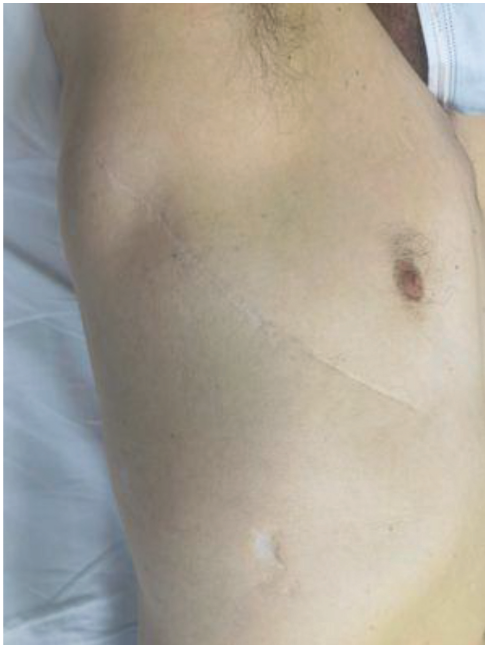
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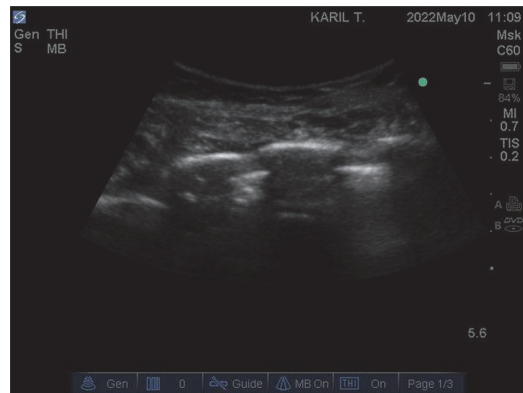
Background and Aims Open thoracotomy is accompanied by severe postoperative pain. In 5–65% of patients who undergo rib retraction during surgery there is intercostal nerve damage, which will lead to chronic intercostal pain.^{1,2}

Ultrasound guided ntercostal block is an effective method of interventional treatment of this type of pain.³

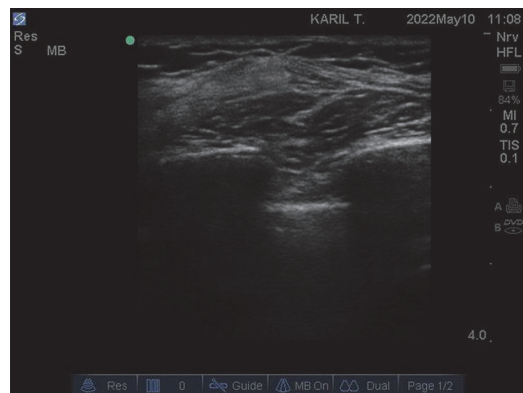
Methods We will describe a case of a 56-year-old patient who underwent open thoracotomy 4 years ago due to surgical treatment of lung cancer. Postoperatively, the patient had chemotherapy and radiotherapy. Also, postoperatively, intercostal pain occured at the site of thoracotomy, which extended to the anterior thoracic wall and mamilla of the mammary gland. The patient described the pain as severe burning. He was initially treated by an oncologist with non-steroid anti-inflammatory drugs, opiates but the pain only subsided, never disappeared. Methadone tolerance developed which the patient has been taking in drops for 4 years and the patient was extremely incapable of performing everyday activities. During ultrasound examination we found that there was a significant narrowing of the intercostal space at the site and level of thoracotomy (figure 1,2). We performed ultrasound guided intercostal block and applied 5 ml of bupivacaine 0.5% and 4 mg of dexamethasone. (Figure 3).



Abstract LB12 Figure 1



Abstract LB12 Figure 2



Abstract LB12 Figure 3

Results Within 15 minutes after performing the block, the patient's pain completely subsided. The patient was followed for a period of 30 days, he reported no pain and subsequently did not use analgesics at all.

Conclusions Ultrasound-guided intercostal block applied with a small volume of local anesthetic and corticosteroid is an effective treatment for chronic intercostal pain.

LB13

EVALUATING THE TIMINGS OF REGIONAL ANAESTHESIA FOR RIB FRACTURES TO INFORM SERVICE IMPROVEMENT WITHIN AN ESTABLISHED CHEST TRAUMA PATHWAY

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Background and Aims We have established a multi-disciplinary chest trauma pathway within our hospital which includes guidelines for regional anaesthesia. This service is currently supported by the on-call anaesthetic team, resulting in an increased emergency theatre workload. We sought to evaluate timings of admission, referral, review, and placement of regional anaesthesia to inform service improvement.

Methods 38 patients with 'rib fractures' or 'chest injury' were identified via the TARN (trauma audit and research network) database over a 3 month period (Oct- Dec 2021).

Exclusions included age <18, isolated sternal fracture, and direct transfer to the major trauma centre (MTC).

Results Patients had an average age of 74, Rockwood frailty score of 3.6. 40% of cases presented on weekends or bank holidays, 34% out of hours (17:00–08:00 Monday-Friday) with only 26% presenting during normal working hours (Monday-Friday 08:00–17:00). The mean time from referral to review was 5 hours 26 minutes (range 22 minutes to 21.5 hours) with an average time to block placement an additional 5 hours 40 minutes (range 33 minutes to 22 hours). Most blocks were performed out of hours (33% weekday night, 17% weekend day, and 28% weekend night), with only 22% during weekday daylight hours.



Abstract LB13 Figure 1

Conclusions The majority of referrals and blocks are performed out of hours which can introduce significant delays. We aim to implement a dedicated block service for catheter insertion during daylight hours, and provision of single-shot blocks out of hours with a view to improving early access to regional anaesthesia for chest trauma.

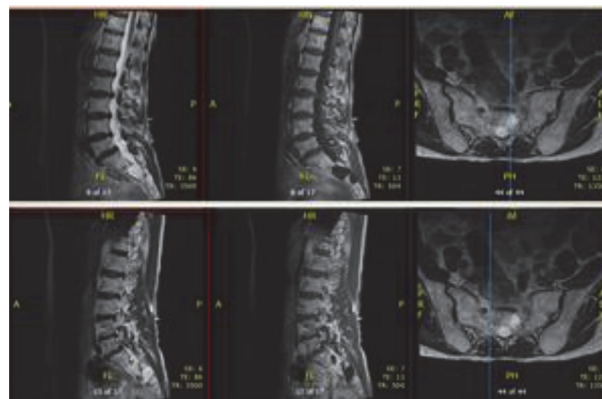
LB14 DO TARLOV CYSTS USUALLY CAUSE BACK PAIN?

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Background and Aims 61-year-old lady case of Complex Regional Pain Syndrome involving the left foot and ankle due to Left foot crush injury (3-foot fractures/first proximal phalanx and first metatarsal). Her pain has been refractory to pharmacotherapy and SCS trial then she developed new symptoms and changes in the pain character as lower back and the left buttock radiating in the outer aspect of the left posterior thigh and radiating down the calf into the outer aspect of the foot and the sole of the foot. Urgent MRI showed: Multiple prominent bilateral perineural nerve root sleeve cysts that are Tarlov cysts within the sacral spinal canal tracking along with the proximal exiting nerve roots.

Methods



Abstract LB14 Figure 1

Results Tarlov cysts are an uncommon cause of back pain. Tarlov cysts are fluid-filled sacs that most often affect nerve roots at the lower end of the spine. Such cysts typically cause no symptoms and are found incidentally in magnetic resonance imaging (MRI) studies done for other reasons. (1)

Conclusions in some cases, the cysts expand, putting pressure on the affected nerve root. The results may include sharp, burning pain in the hip and down the back of the thigh, possibly with weakness and reduced sensation all along the affected leg and foot. Tarlov cysts sometimes enlarge enough to cause erosion of the surrounding bone, which is another way they may cause back pain.

In most cases, Tarlov cysts require no treatment. For those that do, some surgical treatments — such as draining the cyst, have had promising results. (1)

LB15 COMPARING POSTOPERATIVE ANALGESIC EFFECTIVENESS OF ULTRASOUND GUIDED ILIOINGUINAL-ILIOHYPOGASTRIC TRANSVERSUS PLANE-BLOCK AND TRANSMUSCULAR QUADRATUS LUMBORUM PLANE BLOCK IN CAESARIAN SECTION

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Background and Aims Both IL-IH TAP PLANE and TRANSMUSCULAR QL blocks are used in providing postoperative analgesia for abdominal surgeries. Here we are comparing these two techniques in post caesarian section surgery in terms of VAS scores, first rescue analgesia, total analgesic consumption, ease of identifying sonoanatomy and time taken to perform block. It has been shown by several studies that TRANSMUSCULAR QL block gives both visceral and somatic analgesia, there by providing better analgesia.

Methods 40 parturients undergoing caesarian section with ASA grade I, II & III were included. This is a prospective randomised singleblinded study. The patients are divided into two groups. Group I and Group Q. Group I received 20 ml of 0.125% Bupivacaine deposited IL-IH TAP plane. Group Q received 20 ml of same drug deposited in TRANSMUSCULAR QL plane on both sides. An observer blinded to the block given records the VAS scores, first rescue analgesic dose & total analgesic consumption. We also observed the time taken to perform block and ease of identifying sonoanatomy.