Background and Aims  The primary aim was to access postoperative mobility, secondarily to measure the length of hospital stay, pain score, opioid consumption, and side effects.

Methods  After ethical committee approval, a retrospective study was conducted with 50 patients who underwent primary THA. Twenty-eight patients received PENG block after spinal anaesthesia (SA) (Group-PENG), 7 patients had general anaesthesia with PCA postoperatively (Group-PCA), and the remaining 15 received SA with fascia-iliaca block (Group-FIB). The mobilisation was attempted in all patients (ability to stand and walk a few steps with a walker) after 10 hours of surgery. Data was collected for average postoperative pain score, time of mobilisation, total opioid consumption, opioid-related side effects, and discharge time from the hospital.

Results  In the Group-PENG, 26 patients (n=28) were mobilised within the first 10 hours without any opioids. All other patients received average 9 ± 2.1 mg morphine before mobilisation. The average time of discharge (hours) from the hospital (22.1±4.9) was also significantly lower in Group-PENG compared to all others (31.7 ± 3.4, p=<0.01). Average postoperative pain score was significantly low in Group-PENG within the first 48 hours. Opioid-related complications were least in Group-PENG.

Conclusions  The PENG block helps in early mobilisation and enhanced recovery after THA. It provides adequate analgesia for early mobilization and is easy to perform in the supine position after spinal analgesia.

Background and Aims  Internationally obstetric anesthesia guidelines recommend regional over GA for most cesarean deliveries. Continuous caudal anesthesia in obstetric anesthesia was first reported in 1943, after which lumbar access to the peridural space became widely used. We report the anesthetic management of a parturient with difficult spine in whom we were able to place a US guided continuous caudal catheter and provide adequate anesthesia for the surgery.

Methods  25 yr old primigravida with 38 weeks gestation, short stature(121.8 cms) with a thoracic gibbus and difficult airway was posted for caesarean section. MRI of the spine could not be done due to financial constraints. Preprocedural scanning of the neuraxis done in view of altered spine anatomy. Spinal anesthesia could not be achieved despite multiple attempts due, since neuraxial scan revealed good view of caudal space, a continuous caudal catheter was placed under ultrasound guidance using 18 G Tuohy needle.

Results  A sensory block of T6 and motor block of Bromage scale 4 was achieved with incremental fractionated doses of lignocaine.
16 ml 2% lignocaine with adrenaline. Surgery uneventful with minimal hemodynamic perturbations. Time taken for 2 segment regression of sensory block in this case was around 245 minutes.

Conclusions A continuous caudal catheter placed under ultrasound guidance can be considered as a safe modality for providing anesthesia/analgesia in parturients with a difficult spine anatomy.

**LB20** BILATERAL SUPERFICIAL CERVICAL PLEXUS BLOCK FOR AWAKE PARATHYROIDECTOMY IN A HIGH RISK PATIENT

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**Background and Aims** Regional blocks as sole anaesthetic techniques are gaining importance, particularly in patients with extensive comorbidities, where general anaesthesia is high risk. Blocks for surgeries involving neck are more challenging and carry high risk due to the presence of vital structures around. This report describes anaesthetic management of awake parathyroidectomy with bilateral cervical plexus block in a high risk patient.

**Methods** 81 years male with history of CAD for 20 years, past MI, CABG with 3 grafts, chronic heart failure, poor functional capacity, NYHA class III, uncontrolled hypertension, TIA thrice in the past, hypercholesterolemia, fatty liver with deranged liver functions and stage 3 CKD, has been posted for elective parathyroidectomy for refractory hypercalcemia. He was evaluated in preoperative clinic, options of anaesthetics discussed and decided for regional technique. On the day of surgery, he was made to lie down with 30° head-up tilt, standard AAGBI monitors connected, iv cannula inserted, aseptic precautions undertaken, neck ultrasound performed, ‘Stop before the block’ adhered to; Left Superficial cervical plexus block performed with 50mm NRfit needle viewing needle in-plane with ultrasound using 10ml 0.5% levobupivacaine. The same procedure is repeated on right side.

**Results** After 15 minutes waiting time, block assessed at surgical site with pin-prick. After ensuring that block quality is good, he was started on conscious, arousable sedation with propofol TCI. Procedure lasted for 80 minutes and the patient was comfortable and pain free. Peri-operative period was uneventful.

**Conclusions** Bilateral cervical plexus blocks can be used as sole anaesthetic technique in experienced hands for selected patients, particularly high risk ones.

**LB21** BLOOD PATCHES IN OBSTETRIC POPULATION – SINGLE CENTRE EXPERIENCE

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**Background and Aims** Post dural puncture headache is relatively common in obstetric patients who have received central neuraxial anaesthesia. Symptoms of PDPH are often severe, debilitating and potentially long lasting. Treatment options for PDPH are limited and the only treatment which has been shown to be effective is an epidural blood patch. EBP carries risks in itself and the decision to perform this is not taken lightly. Performing an EBP requires appropriate assessment of the patient, consenting of the procedure and follow up among other recommendations.

**Methods** We anonymously retrospectively looked collected data regarding all epidural blood patches performed in a single centre over a 4 year period. Details of the dural puncture, onset of symptoms, consent, documentation of risks, procedure details and follow up were all recorded. We have compared this to the OAA recommendations.

**Results** 23 blood patches in 20 patients, 8 patients had only spinal, 2 had an epidural followed by spinal while 10 had only epidural procedure. Headache developed within 48h in 17 cases, Blood patch was performed between day 2 and day 6 in 18 patients. There is one patient that had blood patch day 10 and 13 with complete resolution of symptoms day 14 from initial epidural, and another patient that had blood patches day 3 and 23 post initial spinal, in the epidural group 8 were recognised as dural taps on insertion.

**Conclusions** We have practice according to OAA recommendations, they were adequately consented and they were given 48h of conservative treatment and they were followed up adequately.

**LB22** IMPROVING THE SAFETY OF REGIONAL ANAESTHESIA LOCALLY IN PAEDIATRIC PATIENTS

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**Background and Aims** Regional anaesthetic (RA) techniques provide high quality paediatric post-operative analgesia. Unfortunately, wrong sided block (WSB) incidence remains unacceptable at 1 in 6250. Potential adverse consequences include patient distress and wrong-side surgery. NHS England classify this as a ‘Never Event’ and have worked with the Safe Anaesthesia Liaison Group (SALG) to implement the ‘STOP Before You Block’ (SBYB) initiative to eradicate WSB. Additionally, the National Patient Safety Agency (NPSA) have created clear standards for surgical site marking (SSM). Following an incidence of WSB, we sought to improve departmental RA safety with the following aims through evaluation of the SBYB process and SSM standards.

**Methods** We undertook two snapshot questionnaires. Firstly, we explored anaesthetic SBYB application over 1-week. Secondly, we audited the NPSA SSM criteria over 3-weeks. This two-step process evaluated current RA safety mechanisms.

**Results** 10 responses were collected from the SBYB survey. All RA techniques performed SBYB; however, only 60% were documented. There was confusion over when SBYB should be performed, with some checking immediately prior needle insertion and others 30–45 minutes before block performance at ‘WHO Sign In’.