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.

**Abstracts**

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

T Azad*, B Kesavan, K Manoharan. University Hospital of North Tees NHS Foundation Trust, Stockton on Tees, UK

10.1136/rapm-2022-ESRA.539

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, CAGB 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.

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

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10.1136/rapm-2022-ESRA.541

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 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.

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

O Babau*, A Qureshi, V Venkatesh. University of Birmingham Hospitals NHS Foundation Trust, Birmingham, UK

10.1136/rapm-2022-ESRA.540

Background and Aims Post dural puncture headache is relatively common in obstetric patients who have received central neuraxial anaesthesia1. Symptoms of PDPH are often severe, debilitating and potentially long lasting2. Treatment options for PDPH are limited and the only treatment which has been shown to be effective is an epidural blood patch3. 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.
Background and Aims  Aspiration accounts for 50% of anaesthesia related deaths. Inadequate pre-operative risk assessment is one of the contributing factors. Point-of-care gastric ultrasound (POCUS-USG) is a novel but valid diagnostic tool to quantify gastric volume (GV) and ascertain risk of aspiration.

The aims of our project were to determine, in fasted patients undergoing emergency surgery:

- if quantitative and qualitative methods of assessment of gastric volume (GV) correlate with each other
- if GV assessment identifies at high risk of aspiration, and
- if higher risk of aspiration was identified, whether this changed the plan for airway management

Methods  Patients booked onto the emergency list were prospectively scanned using low frequency 1–5MHz curvilinear transducer. GV was estimated by inputting cross sectional area – spectively scanned using low frequency 1–5MHz curvilinear transducer. GV was estimated by inputting cross sectional area

Results  There was 100% (n=15) correlation between qualitative and quantitative methods. 3 were identified at high risk of aspiration (GV >1.5ml kg^-1). All these patients were fasted >6h. 2 had a change in airway plan and 1 patient was undergoing a regional technique.

Conclusions  Fasting >6h does not always preclude a high risk of aspiration. POCUS-USG can aid decision-making as part of a multi-modal assessment of aspiration risk to improve patient safety. Ethics approval not required.

Abstract LB24 Table 1

Table: Results from Surgical Site Marking Questionnaire

<table>
<thead>
<tr>
<th>Surgical Site Marking (SSM) questionnaire responses</th>
<th>n=45</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correct labelling of mark on multiple sites</td>
<td>n=5  (100%)</td>
</tr>
<tr>
<td>Labelling with water insoluble pen</td>
<td>n=41  (91%)</td>
</tr>
<tr>
<td>Marking using correct arrow symbol</td>
<td>n=41  (91%)</td>
</tr>
<tr>
<td>Checking the surgical mark at the WHO Time Out</td>
<td>n=38  (84%)</td>
</tr>
<tr>
<td>Visibility of mark after prepping and draping</td>
<td>n=29  (65%)</td>
</tr>
</tbody>
</table>

Background and Aims  After surgical correction of proximal femoral fractures or total hip arthroplasty severe pain scores are expected. Insufficient pain control in the postoperative period compromises recovery and increases the risk of developing chronic pain. Periarticular nerve group (PENG) block, described in 2018, is an interfascial plane block that targets the articular branches of the femoral, obturator, and accessory obturator nerves. Blocked branches convey nociceptive information, preserving motor function and, as such, early ambulation and active collaboration in rehabilitation programs are favored. This study aims to compare the analgesia provided by PENG block with that obtained by performing femoral nerve block or iliac fascia block.

Methods  A retrospective study was performed including patients from 2018 to 2022 who underwent total hip arthroplasty or surgical correction of traumatic proximal femoral fractures. The effectiveness of PENG block, iliac fascia block and femoral nerve block was compared by using pain scores and requirement of rescue analgesia. This work was approved by the ethic committee.

Results  A total of 479 patients were enrolled for this study. Comparing the different techniques of locoregional analgesia performed, no differences were found.

Conclusions  The PENG block appears to be an easy-to-perform technique with the benefit of preserving motor function associated with adequate control of postoperative pain, allowing adherence to early rehabilitation programs, reducing the risk of falls and patient satisfaction.

Abstract LB25

Table: Results from Surgical Site Marking Questionnaire

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</table>

Background and Aims  Fluoroscopy-guided epidural interlaminar lumbar steroid injections (FEISI) widely used for managing low back pain (LBP). There is lack of data on cumulative radiation dose (CRD) in patients receiving more than one FEISI (1).

It is very important to determine CRD for three consecutive FEISI and to define factors that correlate with higher dose area product (DAP) or prolong fluoroscopy time (FT).

Methods  Three groups of patients: LBP duration for one, two and more than two years. One-way ANOVA and independent t-test used to compare FT.

Results  64 females and 36 males (mean age 51 y.o.), mean LBP time 2.1 years. Mean cumulative DAP 833.54±Gycm2

Conclusions  Although SBYB is performed routinely, we found scope to improve documentation and ensure better adherence to national guidance. Following departmental teaching, we placed SBYB posters throughout, created specific RA procedure trays, and created reminders on our online documentation. These changes were reflected in our locally created protocol. Currently, we seek to improve SSM through liaison with our surgical colleagues, and increasing the vigilance of theatre staff undertaking appropriate checks.