

## Abstract LB22 Table 1

Table 1: Results from Surgical Site Marking Questionnaire

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

**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.

### LB23 POINT-OF-CARE GASTRIC ULTRASOUND: A TRAINING OPPORTUNITY TO ENHANCE DECISION-MAKING AND IMPROVE PATIENT SAFETY?

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**Background and Aims** Aspiration accounts for 50% of anaesthesia related deaths. Inadequate pre-operative risk assessment is one of the contributing factors.<sup>1</sup> Point-of-care gastric ultrasound (POC-USG) is a novel but valid diagnostic tool to quantify gastric volume (GV) and ascertain risk of aspiration.<sup>2</sup>

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 of the antrum in the right lateral decubitus position (RLD-CSA) into a validated model<sup>2</sup>. This was compared to acceptable GV determined by the patient's weight (low risk for aspiration =  $<1.5\text{ml kg}^{-1}$ ; high risk  $>1.5\text{ml kg}^{-1}$ )<sup>2</sup>. Qualitative assessment was categorised as grade 0–2 based on antrum appearance. Risk was communicated to the anaesthetist and the final airway plan recorded.

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

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

### LB24 PENG BLOCK FOR POSTOPERATIVE ANALGESIA IN PATIENTS UNDERGOING SURGICAL CORRECTION OF TRAUMATIC PROXIMAL FEMORAL FRACTURES OR TOTAL HIP ARTHROPLASTY

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**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. Pericapsular 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.

### LB25 CUMULATIVE RADIATION DOSE EXPOSURE IN FLUOROSCOPY-GUIDED EPIDURAL INTERLAMINAR LUMBAR STEROID INJECTIONS

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**Background and Aims** Fluoroscopy-guided epidural interlaminar 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 833.54cGycm2

(SD 266.32), mean FT 62.23s (SD 13.22s); strong positive correlation between FT and DAP ( $r=0.545$ ;  $p=0.01$ ). Mean FT during 1st procedure 18.1s, 2nd - 20.7s, 3rd - 23.43s. Mean DAP during 1st procedure 226.24cGycm<sup>2</sup>, 2nd - 257.33cGycm<sup>2</sup>, 3rd - 349.97cGycm<sup>2</sup>. FT and DAP positively correlate in each group. First epidural steroid injection time  $p=0.750$ , 2nd 0.767, 3rd 0.682 ( $p=0.01$ ). First FT was longer in LBP for more than 2 years ( $p=0.05$ )  $n=38$  (mean 25.4s); LBP less than 1 year  $n=36$  (mean 22.51s) and LBP from 1–2 years  $n=26$  (mean 14.32s). Mean DAP was higher during 3 procedures and LBP longer than 5 years ( $p=0.05$ ).

**Conclusions** DAP is in uphill linear relationship with FT. Mean cumulative dose is 57 times lower than radiation dose for FEISI allowed by Society of Interventional Radiology of Europe. Patients with longer LBP have longer FT and higher DAP, probably due to severe degenerative spinal lesions.

#### LB26 RECTUS SHEATH BLOCK AND MULTIMODAL ANESTHESIA FOR ANESTHETIC MANAGEMENT IN EMERGENCY ABDOMINAL SURGERY: A CASE SERIES

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**Background and Aims** Rectus sheath block (RSB) is a regional anesthesia technique, that provides somatic analgesia (without visceral analgesia) by blocking the ventral rami of the 7th to 12 th intercostal nerves with injection of local anesthetic in the space between the rectus abdominis muscle and the posterior rectus sheath.<sup>1</sup> It can be used as a part of multimodal analgesia together with usage of non-opioid drugs, such as lidocaine, ketamine and magnesium, given as a continuous intravenous infusion during midline incisions in emergency open abdominal surgeries. Multimodal analgesia is recommended for pain management following major surgery.<sup>2</sup>

**Methods** We are presenting four cases of emergency open abdominal surgeries where bilateral RSB was performed with 0.25% bupivacaine after induction to general anesthesia. All patients received 4 mg dexamethasone and a continuous intravenous infusion with 2 mg/kg/h lidocaine, 0.2 mg/kg/h ketamine and 20 mg/kg/h was given till the end of surgery. All patient received 1 gr metamizole at the end of operation. In the postoperative period pain was followed with Visual Analogue Scale (VAS) score 2, 6, 12, 24, 36, 48 and 72 hours after operation and analgesia regime included metamizole 1 gr four times a day. For pain of 6–10/10 1 mg/kg tramadol was given.

**Results** During surgery request for opioids was lower and pain scores in the first 72 hours after surgery were reduced too.

**Conclusions** Bilateral rectus sheath block with continuous intravenous infusion of lidocaine, ketamine and magnesium provides sufficient analgesia during emergency laparotomies, lower opioid requirements during and after surgery, prolong neuromuscular block and all patient were hemodynamically stable.

#### LB27 THE EFFECT OF PARAVERTEBRAL ANAESTHESIA ON QUALITY OF LIFE SCORES IN BREAST CANCER PATIENTS

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**Background and Aims** Breast cancer is the commonest cancer worldwide. (1) Multiple level paravertebral anaesthesia (PVA) provides excellent analgesia with minimal PONV (2); therefore, we wanted to ascertain if PVA would improve quality of life (QoL) at 2 weeks postoperatively in these patients.

**Methods** We included female patients of > 18 years, of ASA I-III, scheduled to undergo breast cancer surgery after ethics committee approval. Three validated QoL questionnaires for cancer patients were administered preoperatively and 2 weeks postoperatively i.e. the European Organisation for Research and Treatment of Cancer - QLQ-C30 (primary outcome), BR-23, the FACT-B and WHOQOL-bref questionnaires. (3–5)

PVA group patients received USG, in-plane, PVA at T1-T6 levels together with Pecs-2 block and propofol sedation whereas the GA group received standard GA.

**Results** 65 patients were randomised: 34 in the PVA and 31 in GA group. Demographics were comparable except for younger age of PVA patients. At 24 hours lower pain scores (movement), lesser fentanyl consumption was observed in PVA patients [365 mcg (215, 595)] versus GA group [820 mcg (565, 1035)],  $P=0.0001$ . QLQ-C30 scores at 2 weeks post-surgery (global health-QoL, physical, role, cognitive, social functioning) were significantly better in PVA as compared to GA patients after age and baseline score adjustment. Intra-group analysis revealed significant fall in body image, sexual functioning, breast, arm symptoms (QLQ-BR23 scores) and lower emotional, functional scores (FACT-B, WHOQOL-bref) in the GA group.

**Abstract LB27 Figure 1**

**Conclusions** Therefore, emotional, physical and functional quality of life was better maintained in PVA patients as compared to GA patients at 2 weeks post-surgery.

#### 001 REGIONAL ANESTHESIA SAVES THE DAY WHEN INTUBATION IS BEST AVOIDED

Onur Kumcu.

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There're many benetits of using regional anesthesia(RA) but sometimes performing RA compared to general anesthesia(GA) has some life saving advantages. I would like to share one of our experiance.

51-year-old male patient presented with multiple rib, tibial and scaphoid fractures due to fall from tractor and planned for external fixation. He was 180 cm tall, weighed 120 kg, had a history of obstructive sleep apnea (OSA) and 60 pack-year of smoking. He wasn't operated before, not on any medications, not allergic to drug and didn't use cpap or oral device for osas.

He was found conscious, pulse rate(PR) 88/min, blood pressure(BP) 160/80mmHg and SpO2 94. Airway investigation revealed mallampati score 3, mouth opening 4cm, thyromental