

Methods A woman presented with severe chronic neuropathic pain on the medial side of the lower leg and ankle. The worst pain was localized to the MM. Diagnostic nerve blocks were performed in the following order: 1) SN; 2) MFCN-A; 3) MFCN-P (figure 1 and 2).

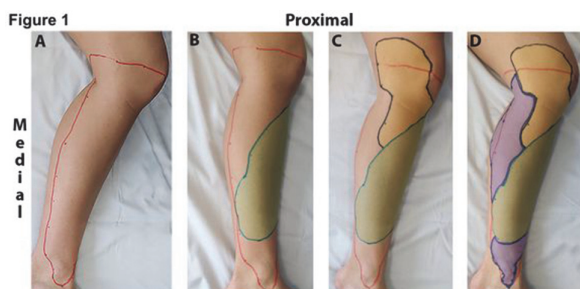


Figure 1 shows the medial part of the lower leg and ankle of a 37-year-old woman with chronic neuropathic pain following anterior cruciate ligament surgery two years previously. 1A shows the neuropathic area (red outline) defined by pinprick. 1B shows the area anesthetized after diagnostic SN nerve block (green area). 1C shows the area anesthetized after MFCN-A block (yellow area). 1D shows the area anesthetized after MFCN-P block (purple area), which was the area where the worst pain was localized. Photos and case used following written informed consent from the patient (BMJ consent form). MFCN-A, anterior branch of the medial femoral cutaneous nerve; MFCN-P, posterior branch of the medial femoral cutaneous nerve; NRS, numeric rating scale; SN, saphenous nerve. Printed with permission from Siska Bjørn.

Abstract B1 Figure 1

Figure 2

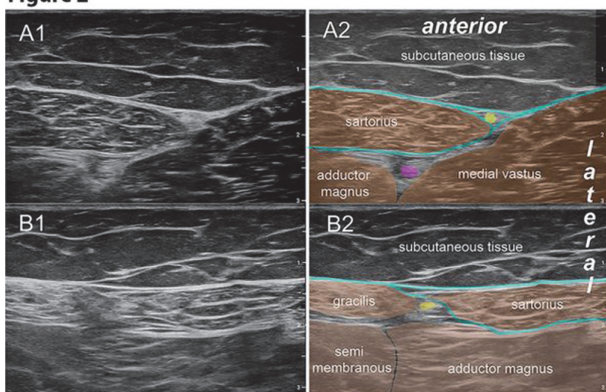


Figure 2. A1 shows the anterior branch of the medial femoral cutaneous nerve (MFCN-A) and the saphenous nerve (SN). B1 shows the posterior branch of the MFCN (MFCN-P). A2 and B2 are graphic overlays of A1 and B1, respectively. The MFCN-A is indicated by a yellow profile and SN by a purple profile in A2. The MFCN-P is indicated by a yellow profile in B2. The cyan stripes in A2 and B2 indicate the fascia lata that envelops the sartorius.

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Abstract B1 Figure 2

Results The SN, MFCN-A and MFCN-P all innervated part of the skin in the neuropathic area. SN block alone marginally reduced NRS, whereas additional MFCN-A block did not further reduce NRS. MFCN-P block anesthetized the area around the MM and significantly reduced the pain. Perineural botox was injected around the SN and MFCN-P. At 2-weeks follow-up NRS was significantly reduced (table 1) and patient satisfaction high.

Abstract B1 Table 1

Pain score, NRS	At rest	During activity	Provoked
Baseline	2	6	10
After diagnostic SN block	2	5	10
After diagnostic MFCN-A block	2	5	10
After diagnostic MFCN-P block	0	0	2
2 weeks after botox injection	0	3	6

Diagnostic block with Lidocaine 1%. MFCN-A, anterior branch of the medial femoral cutaneous nerve; MFCN-P, posterior branch of the medial femoral cutaneous nerve; NRS, numeric rating scale; SN, saphenous nerve.

Conclusions We present a novel selective MFCN-P block, which may be important in the diagnosis and treatment of chronic neuropathic pain.

B2 EFFECT OF BILATERAL SUBJECTO-INTERFASCIAL PLANE BLOCK ON PERIOPERATIVE FENTANYL CONSUMPTION UNDERGOING CORONARY ARTERY BYPASS GRAFTING: A PROSPECTIVE RANDOMISED CONTROLLED TRIAL

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Background and Aims Pain following sternotomy has always remained a major concern for patients undergoing open heart cardiac surgery during the entire perioperative period. The incidence of rest pain due to midline sternotomy is as high as 49% following coronary artery bypass grafting (CABG). We planned to utilize subjecto-interfascial plane (SIP) block to determine its efficacy and quality of analgesia as compared to conventional intravenous analgesia.

Methods After institutional ethics committee approval, we recruited 60 (NYHA I and II) patients and randomized them into group1 as SIP block and Group2 as nurse controlled analgesia (NCA). Patients with serious comorbidities were excluded from the study before randomisation. Group1 patients received the allocated USG guided block after induction of GA. A mixture of inj ropivacaine (0.375%) and dexmedetomidine (1.1 mcg/ml) was used for six injections of 6 ml each at 2nd,4th, and 6th intercostal space in bilateral parasternal region. All patients were monitored and their vitals recorded. Total rescue analgesia in PACU/ICU, peak inspiratory flow rate, time to extubation, time to first oral intake and total length of ICU stay were also recorded.

Results The total fentanyl consumptions after 24 hrs were compared between the groups using one-way ANOVA and post-hoc analysis. Group 1 used significantly less fentanyl compared to the control group (715.66 ± 127.45 mcg vs 1411.96 ± 144.66 mcg; $P < 0.001$) (Plotted graph attached).

Conclusions The SIP block was found to be superior in terms of pain control following midline sternotomy during CABG. Total fentanyl consumption was significantly reduced when compared with conventional therapy.