Background and Aims
The objective of the study was to compare ultrasound-guided supraclavicular and axillary plexus blocks for upper extremity surgery of the elbow, forearm, wrist, and hand.

Methods
Randomized controlled trial. Sample size was 80 patients randomized into two groups. ASA 1 & 2 Patients for surgery of elbow, forearm, wrist and hand were included. Lack of consent, pregnancy, infection at the site of injection, allergy to LA and coagulopathy were exclusion criteria. Study was conducted after IRB and ethical committee approval. Written & informed consent was taken. Patients were divided into 2 groups Supraclavicular and Axillary group. 30 ml 0.5% Bupivicane was the local anaesthetic used.

Results
There was no difference between the 2 groups in terms of success rate (95–97%), block-related pain scores, vascular puncture, and paresthesia. Compared with the supraclavicular approach axillary approach required a higher number of needle passes (6.4 vs 2.1) with a P value of 0.003, longer needling time (7.2 mins vs 4.1 mins) with a P value of 0.012, longer performance time (7.9 mins vs 5.0 mins) with a P value of 0.009 and longer total anaesthesia-related time (26.0 mins vs 23.1 mins) with a P value of 0.03. Supraclavicular blocks resulted in a higher rate of Horner syndrome (37.5% vs 0% P value of 0.001)

Conclusions
Ultrasound guidance results in similar success rates, block-related pain scores, incidences of paresthesia and vascular puncture for the SCB and AXB. Total performance time and total anaesthesia related time was significantly less for SCB group when compared to AXB group.
Abstract B28 Figure 3  Bilateral EOI catheters in-situ for transitional postoperative pain management in a patient who underwent pancreateoduodenectomy

Results  All patients remained pain and opioid free and able to mobilise and breath effectively. All patients were very satisfied with analgesia provided by the EOI catheters.

Conclusions  With the evolution of regional anaesthesia techniques, the opioid use in acute pain management needs to be re-evaluated.\(^2\) We used the EOI block to provide enhanced recovery analgesia\(^3\) for pancreateoduodenectomy. We have shown that a regional block could be used for step-down analgesia to avoid opioid use and improve outcomes.

Abstract B29 Figure 1

WHEN REAL TIME ULTRASOUND GUIDED CAUDAL BLOCK IS THE ONLY FEASIBLE OPTION: A CASE REPORT

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Background and Aims  Kagami ogata syndrome (KOS) patients present with craniofacial dysmorphism, thoraco abdominal abnormalities, and kyphoscoliosis. The choice of regional anesthesia poses a real challenge as the reliance on the usual regional anesthetic techniques including lumbar epidural, paravertebral, fascial plane blocks, and landmark caudal blocks can be very challenging.

Methods  We elected to perform a real time ultrasound (US) guided caudal epidural block (CEB) in a patient with a medically challenging spine anatomy to identify the midline, depth, and level with spread of local analgesia into the caudal epidural space.

Results  All patients remained pain and opioid free and able to mobilise and breath effectively. All patients were very satisfied with analgesia provided by the EOI catheters.

Conclusions  This report should encourage pediatric anesthesiologists to familiarize themselves with ultrasound guided caudal blocks as certain situations will dictate such a need.

B30  THE IMPACT OF ULTRASOUND GUIDED BRACHIALPLEXUS BLOCK ON THE OUTCOME OF ARTERIOVENOUSFISTULA CREATION

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Background and Aims  Successful vascular access in the upper arm for hemodialysis is crucial for patients with end stage renal insufficiency. Arteriovenous fistula (AVF) is the vascular access of choice in this patient population. Different techniques (general, regional, local anesthesia) have been implemented to produce surgical anesthesia. Regional anesthesia (RA) in the form of ultrasound guided brachial plexus block (UGBPB) has been shown to increase success and maturation rates of AVF, producing perioperative sympathectomy-like effects, vasodilation and increased AVF blood flow. This review seeks to present and synthesize the literature regarding the impact of UGBP on the outcome of AVF creation.

Methods  An extensive search of the electronic databases of “PubMed” and “Google Scholar” was conducted using the phrases “anesthesia”, “regional anesthesia”, “brachial plexus block”, “ultrasound guided brachial plexus block”, “regional versus local anesthesia” in combination with “arteriovenous fistula” or “end stage renal disease”.

Results  Eight heterogeneous studies reporting on 856 patients were included in this review. They are five randomized controlled and three prospective studies. UGBP was carried out using the supraclavicular, infraclavicular or axillary approach. UGBP produced higher AVF blood flow in the early and late postoperative period and higher primary AVF patency rates than local anesthesia. In some studies RA modified the type of AVF.

Conclusions  UGBP causing vasodilatory by unknown mechanism that mimics parasympathetic nervous system action enhances AVF patency and maybe modifies surgical plan. Large scale, randomized controlled trials, focusing on randomization method, are necessary to produce safe conclusions.

B31  BILATERAL DUAL TAP BLOCK FOR MAJOR ABDOMINALSURGERY – A SERIES OF CASE REPORTS

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Background and Aims  Ultrasound-guided transversus abdominis plane (TAP) block is a regional anesthesia technique which, as part of a multimodal analgesia regimen, may provide an alternative to epidural analgesia. We report 3 cases of patients where a bilateral dual TAP block (subcostal and lateral approaches) was used to minimize opioid use after major abdominal surgery.

Methods