

- 73 years' old female, ASA III, with advanced ovarian carcinoma and extensive peritoneal carcinomatosis, who underwent emergency median laparotomy and colostomy for intestinal occlusion;
- 67 years' old female, ASA III, with localised scleroderma scheduled for open left hemicolectomy for a colon tumour;
- 62 years' old male, ASA II, scheduled for hand-assisted laparoscopic resection of a rectal tumour.

A total intravenous anaesthesia and multimodal IV analgesic regimen were used, including paracetamol, non-steroid anti-inflammatory and dexamethasone, alongside an ultrasound guided bilateral dual TAP block at the start of the procedure, with a total of 50–60 mL ropivacaine 0.2% and adequate spread in the relevant planes. Tramadol or morphine were used postoperative as needed.

**Results** Post-operative IV opioid consumption was 12mg morphine or 300mg tramadol in 24 hours, with no opioids required after 48 hours. The pain was well controlled (maximum 2 at rest and 3 with movement out of a 11 points visual analogue scale). The patients reported high satisfaction and no nausea.

**Conclusions** Bilateral dual TAP block was part of an effective opioid-sparing multimodal analgesia for major abdominal surgery, and its benefits as an alternative to epidural analgesia may merit further study.

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### ULTRASOUND-GUIDED CRYONEUROLYSIS OF THE SUPRA SCAPULAR NERVE FOR CHRONIC SHOULDER PAIN: A CASE SERIES

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**Background and Aims** Cryoneurolysis delivered via a cryoprobe for the treatment of acute and chronic pain has been described as far back as 1961.<sup>1</sup> It has previously been described as a treatment for chronic shoulder pain via a landmark technique and acute post-operative shoulder pain via ultrasound guided technique.<sup>2–3</sup> However, its application via ultrasound guidance for chronic shoulder pain has yet to be described.

**Methods** This is a case series of three adult patients who had chronic shoulder pain. All patients had previous landmark-based injections of their suprascapular nerve by their orthopedic surgeon using lidocaine that resulted in pain relief. Patients were seated on the edge of the bed and the suprascapular nerve was identified in the suprascapular notch via ultrasound using a 10–5 MHz probe. Then a 20-gauge 90 mm cryoprobe was advanced in plane in a medial to lateral direction until contact with the suprascapular nerve was obtained. A 106 second treatment cycle was started where an ice ball the size of 7.1 mm wide by 16.0 mm tall was performed. The treatment reached a temperature of -88 Celsius and resulted in second degree temporary nerve degeneration.

**Results** All patients had immediate pain relief with pain reduction to 0. Motor weakness lasted from 14–18 days. Follow up phone calls showed a duration of pain relief of 3–6 months. No adverse events were observed.

**Conclusions** Ultrasound guided cryoneurolysis may have a place in the management of chronic shoulder pain with a duration of pain relief from 3–6 months and motor weakness subsiding by 3 weeks post treatment.

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### SELECTIVE MIDDLE AND INFERIOR TRUNK OF BRACHIAL PLEXUS BLOCK TOWARDS SITE SPECIFIC REGIONAL ANAESTHESIA FORDISTAL FOREARM SURGERY – A PILOT SERIES

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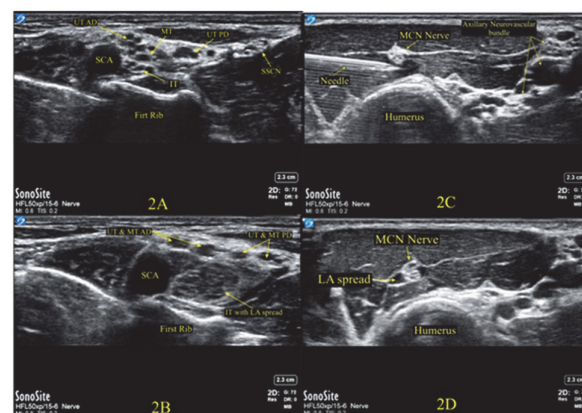
**Background and Aims** Selective supraclavicular nerve and superior trunk blocks are described for clavicle surgeries.<sup>1</sup> This series objective was to observe feasibility of selective middle, inferior trunk (MT/IT) and musculocutaneous nerve (MCN) block towards a site specific regional strategy for distal forearm surgery.

**Methods** After informed consent, 10 patients undergoing distal forearm surgeries underwent selective MT (3 ml), IT (4 ml) and MCN (3 ml) blocks with equal mixture of local anaesthetics (2% Lidocaine and 0.5% Bupivacaine). MT and IT were identified with systematic sign based scanning.<sup>2</sup> MT was blocked distal to C7 transverse-process where C7 ventral-ramus (VR) appeared multifascicular as hyperechoic honey comb (Figure 1). The IT was blocked where C8 and T1-VR combined over first rib (Figure 2A&B). Subsequently arm was abducted and MCN blocked at the distal axillary crease (Figure 2C & D). Sensory-motor mapping at 30 minutes, strategy success, requirement of rescue measure, analgesic duration and complications were noted (Table 1).



**Figure 1** Showing sonoanatomy of the Middle trunk block  
 1A-Preblock MT; 1B-In-plane needling for the MR block; 1C-MT post block with LA spread  
 Legend: UT\*- Upper Trunk after C5&C6 combine, MT-Middle trunk, C8 – C\* Ventral Ramus, CA-Carotid Artery, IJV-Internal Jugular Vein, VA- Vertebral Artery

#### Abstract B33 Figure 1



**Figure 2** showing the sonoanatomy of the IT and MCN blocks  
 2A: Identification of IT above the first rib; 2B: IT post block performed with out-of-plane needling; 2C: MCN block with In-plane needling; 2D: MCN with LA spread post block.  
 Legends: UT- Upper trunk, MT-Middle trunk, IT- Inferior Trunk, AD- anterior division, PD-Posterior Division, SCA-Subclavian Artery, SSCN-Suprascapular Nerve, LA -Local Anaesthetic

#### Abstract B33 Figure 2

**Results** In all patients MT and IT were identified and blocked. At 30 minutes all patients exhibited complete conduction blockade (CCB) in median, ulnar and musculocutaneous nerve. Radial nerve had sensory-motor sparing in 30% patients, however only one patient required rescue block of radial nerve at the elbow, for surgery completion. At the end of surgery 50% of patients had CCB of the axillary nerve as well.

**Abstract B33 Table 1**

Table 1 – Showing the demographic details and the observed outcomes

|  |               |
|--|---------------|
| Age/years Median (25 <sup>th</sup> to 75 <sup>th</sup> percentile)   | 19 (18 to 33) |
| Gender M/F   | 8/2           |
| BMI/ Kg/m <sup>2</sup> (mean ± standard deviation)   | 23 ± 4        |
| Surgical procedures a/b/c*   | 2/7/1         |
| Surgical Duration/minutes (mean ± standard deviation)  | 52.8 ± 20.9   |
| Strategy Success rate  | 90%           |
| Tourniquet used yes/no   | 9/1           |
| Duration of analgesia/hours  | 6.58 ± 2.76   |
| Incidence of complications – Horner’s syndrome, hemidiaphragmatic paresis, hoarseness of voice, neurological deficit | Nil           |

\*Surgical procedure a - Metal exit from Radius, b - Open fixation with plate of Radius and Ulna, c- K-wire fixation for Little finger.

**Conclusions** Selective MT/IT with MCN block is feasible for surgery proximal to the wrist as well as the medial aspect of hand. Detailed sensory-motor mapping of individual nerves requires further examination to establish site specificity.

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**SONOCLUB – REGIONAL ANAESTHESIA FOR REGION’S ANAESTHETISTS**

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**Background and Aims** Regional anaesthesia (RA) exposure in anaesthetic training in the United Kingdom (UK) is variable, and we hypothesised that many trainees lack confidence performing RA techniques. RA is a core component of the new UK Royal College of Anaesthetists (RCOA) curriculum(1) and a key part of the anaesthetist’s analgesic armamentarium(2).

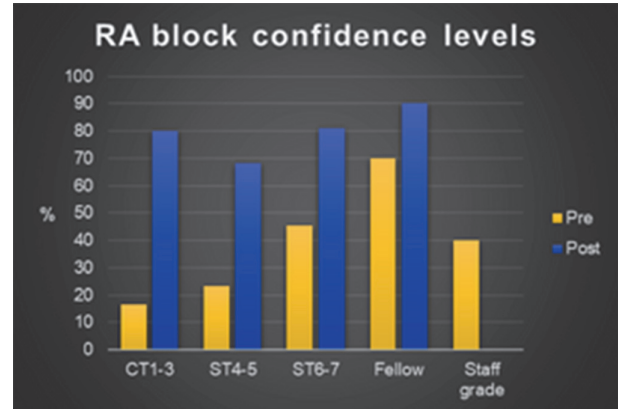
Sonoclub was formed by group of enthusiastic regional anaesthetic trainees with sole aim of inspiring enthusiasm and making anaesthetists in the region more confident in provision of Regional Anaesthesia (RA-UK) “Plan A” and “advanced” blocks. A series of educational events were planned.

**Methods** A programme of teaching sessions, each lasting an hour and focussing on one Plan A and one advanced (Plan B/C) block, was developed.

The emphasis was on spending time scanning human models, with expert guidance to identify anatomy and improve technique. The group was advertised to anaesthetists of all grades via email, WhatsApp® and Twitter®.

Anonymous pre- and post-course feedback on confidence and teaching quality was gathered.

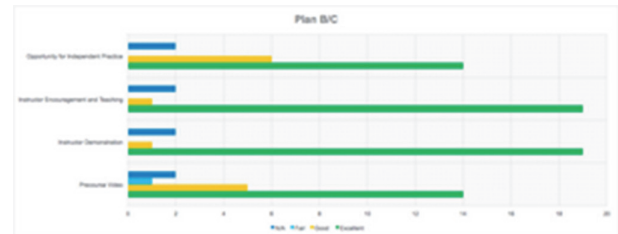
**Results**



**Abstract B34 Figure 1** Comparison of confidence levels pre vs. post Sonoclub



**Abstract B34 Figure 2** Plan A Block feedback



**Abstract B34 Figure 3** Plan B/C Block feedback

**Conclusions**

- Low confidence in plan A block performance, even amongst senior trainees.
- Little prior experience or training.
- Training deficit that will be hard to make up, especially in line with new RCOA curriculum.
- Short, sharp, focussed training sessions are highly valued and can increase participant confidence in block performance.
- Teaching programmes such as Sonoclub will play a key role in ensuring training needs met.