Abstract EP238 Table 3 Assessment of motor, sensory function and adverse effects

Table 4. Assessment of motor, sensory function and adverse effects

	ISB (n = 38)	PLO-SCB (n = 38)	P value
Sensory			
30 min after block (2 / 1/ 0)	34 (89.5) / 4(10.5) / 0(0.0)	31(81.6) / 7 (18.4) / 0(0.0)	0.516
24 h after surgery (2 / 1/ 0)	37(97.4) / 1(2.6)/ 0(0.0)	37(97.4) / 1(2.6)/ 0(0.0)	1.000
Motor			
30 min after block (2 / 1/ 0)	34 (89.5) / 4 (10.5) / 0 (0.0)	33 (86.8) / 4 (10.5) / 1(2.6)	1.000
24 h after surgery (2 / 1/ 0)	37 (97.4) / 1 (2.6) / 0 (0.0)	34 (89.5) / 4(10.5) / 0(0.0)	0.358
Handgrip strength			
Comparing baseline to 30 min after block (kg)	24.76 (24.98)	37.81 (28.26)	0.036
Comparing baseline to 24 h after surgery (kg)	16.83 (19.61)	13.15 (26.12)	0.49
Adverse effects			
Dyspnoea	4 (10.5)	1 (2.6)	0.355
Numbness	4 (10.5)	3 (7.9)	1.000
Motor weakness	1 (2.6)	1 (2.6)	1.000
Horner's syndrome	3 (7.9)	2 (5.3)	1.000
Hoarseness	0 (0.0)	0 (0.0)	1.000

Categorical variables are expressed as number (%). Sensory 2, normal; 1, loss of pinprick sensation; 0, loss of light touch sensation; Motor 2, normal; 1, decreased; 0, none.

Results Incidence of HDP was significantly lower in the PLO-SCB group than in the ISB group at 30 min after block (28 of 38 [73.7%] vs. 0 of 38 [0%]; p<0.001) and 24 h after surgery (18 of 38 [47.4%] vs. 9 of 38 [23.7%]; P=0.002). Pain scores measured immediately (1 [0,2] vs. 1 [0,1]; p=0.06), and 24 h after surgery (6 [4,8] vs. 5 [3,7]; p=0.199) were similar between the two groups.

Conclusions Continuous PLO-SCB showed minimal effect on phrenic nerve function while providing equivalent analgesia to continuous ISB in patients undergoing arthroscopic shoulder surgery. For single-shot injection, low-volume PLO-SCB achieves a 0% rate of HDP while maintaining analgesia. PLO-SCB could be applied even in patients with a high risk of postoperative respiratory complications.

EP239 A CASE OF DYSAUTONOMIA IN CRPS: A NINE YEARS FOLLOW UP OF A VERY RARE AND COMPLEX PATIENT

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Background and Aims CRPS is a debilitating condition of chronic pain that challenges both patient and physician, with often detrimental results that can go all the way even to decision of mutilating the affected limb. Our objective is to evaluate efficacy, decision making and patient satisfaction, as well as complications of treatments of a very rare and complex case of CRPS that progressed with dysautonomia syndrome.

Methods Analysis of data collected from progression of disease through a nine years follow-up of a specific patient with CRPS of the left arm, with onset of symptoms after a procedure for epicondylitis that injured the left radial nerve at the level of the elbow. A review of literature is included to examine the connection of the two conditions.

Results Through the course of nine years the patient underwent approximately 34 interventions, from conservative medical treatments to intravenous ketamine, neuromodulation techniques, spinal injections and other blocks, radiofrequency ablations, intrathecal pump implantation in various pain centers. The recent years there was a need to incorporate treatments also for more generalized autonomic dysfunction, like neurogenic bladder, respiratory and cardiovascular manipulations, and also gastrointestinal dysfunction.

Conclusions CRPS is a condition that requires continues medical care, adjustment of treatments and monitoring for new symptoms. Although it is not clear that dysautonomia directly connects with CRPS, studying cases for a long period of time may reveal there is a common basis. More important is that all symptoms should be addressed in time and any physician's bias should not hinder their diagnosis and treatment.

EP240 DEVELOPMENT AND DELIVERY OF ULTRASOUND GUIDED PERIPHERAL NERVE BLOCK SERVICE IN A HIGH BURDEN LOW RESOURCE SETTING

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Background and Aims Ultrasound guided peripheral nerve blocks (USG-PNBs) have many benefits in a high burden low resource settings. These range from reduced airway related complications to decreased need for opioid analgesics. Barriers to performing USG-PNBs tend to surround education agnd equipment accessibility. At Queen Elizabeth Central Hospital, Malawi, there was access to ultrasound equipment and a learning cohort of over 30 anaesthetic trainee providers. As visiting anaesthetists to Malawi, our aim was to explore the delivery of USG-PNBs within this clinical setting.

Methods An assessment of current practice for performing USG-PNBs in theatres was carried out. This involved reviewing theatre workflow and stakeholder (surgical, recovery, and anaesthetic providers) discussions. Following this, practical teaching and supervision sessions were provided. This included the consent process, anatomy revision using free apps, scanning and needling techniques and safe use of local anaesthetics.

Results We found that stakeholders were receptive to USG-PNB use. Concerns raised included delays to theatre lists and desire for trainee supervision. Collaboration with surgeons and flexibility in timing of blocks increased the delivery of PNBs. Some trainees had received previous teaching, as such, we focused on technique and building confidence. Over a 2-month period, 20 lower limb,14 upper limb and 10 abdominal plane blocks were performed by physician and clinical officer trainees (figure 1).