received ultrasound guided CEB with 1 ml/kg 0.25% bupivacaine. The primary outcome was the proportion of patients requiring rescue analgesia in the 1st 24 hours after surgery. Secondary outcomes were the duration of post-operative analgesia and FLACC scores.

Results Significantly more patients belonging to ESPB than CEB group required rescue analgesia (88.4% versus 42.3% respectively, p value <0.001) in the 1st 24 hours after surgery. The duration of analgesia was shorter in the ESPB group by 9.54 hours (95% CI: 4.51 to 14.57 hours, p=0.000). Though ESPB group patients had satisfactory FLACC scores, they were inferior to CEB group for the first 6 hours after surgery. No adverse effects were reported in both the groups.

Conclusions Both ESPB and CEB were safe and efficacious. CEB provided a longer duration and better quality of analgesia especially in the first 6 hours postoperatively. ESPB may be considered in pediatric patients undergoing abdominal surgery when CEB is contraindicated or difficult.

OP038 CONSENT AND UTILISATION OF PAEDIATRIC PERIPHERAL REGIONAL ANAESTHESIA IN A UK TERTIARY CHILDREN'S HOSPITAL

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Background and Aims Regional anaesthesia (RA) in children is being driven by the translation of adult 'plan A blocks' into paediatrics. Utilisation hosts many benefits including anaesthetic drug sparing on the developing brain, improved recovery profiles and analgesia action on immature pain pathways. We proposed that inaccurate consent information would affect confidence in and uptake of RA. We aimed to review current practice of consent with a forward plan to provide a unified, accurate message to caregivers.

Methods We performed a retrospective audit of patients who had Trauma and Orthopaedic surgery at the Bristol Royal Hospital for Children over a three-month period, identified via our electronic theatre system (Bluespier). These 205 cases yielded 32 who had peripheral RA (15.6%) and their anaesthetic charts were analysed. Standards of consent were set against national guidance (RA-UK/AAGBI).

Results Of the 32 patients, 31 had consent discussions documented with only 21 referencing a named block. The benefits/alternatives were discussed in nine cases while simple post-op analgesia or limb safety was never explained. Risks of RA were discussed in just 10 cases (31%), with block failure advised in only seven.

Conclusions This limited consent may in part reflect the lacking international guidance of RA risks specific to children. To standardise consent we have produced an aide memoire and documentation template that includes recommendations by AAGBI/RCOA alongside specific paediatric RA risk considerations (figure 1). Additionally, we have produced an information leaflet and educated our anaesthetists on recent paediatric-specific data. These tools have begun removing barriers of peripheral RA in our children's hospital.

Peripheral Block:.....
Explained to: .....
☐ Benefits ☐ Alternatives
☐ Q's answered ☐ Leaflet given
Risks:
☐ Failure ☐ LA Toxicity
☐ Nerve injury: temporary/permanent Block specific:
Post Block: ☐ Pain relief ☐ Care of limb
Comments:

Abstract OP038 Figure 1 Paediatric consent aide memoire and documentation template

Peripheral nerve blocks – Free papers 4

OP039 SUPERIOR TRUNK BLOCK IS AN EFFECTIVE PHRENIC-SPARING ALTERNATIVE TO INTERSCALENE BLOCK FOR SHOULDER ARTHROSCOPY: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Background and Aims The Superior Trunk Block (STB) is being considered as an alternative to Interscalene Block (ISB) for shoulder arthroscopy. This study aims to compare efficacy and safety between these techniques.

Methods PubMed, EMBASE, Scopus and Cochrane were searched for randomized controlled trials (RCTs) comparing the STB to the ISB for shoulder arthroscopies. Outcomes assessed included incidence and extent of hemidiaphragmatic paralysis, pain scores, opioid consumption, patient satisfaction, block duration, and block-related complications. RevMan 5.4 analyzed data. Risk of bias was appraised using the RoB-2 tool.

Results We analyzed 4 RCTs involving 359 patients, of whom 49.5% underwent STB. The results showed that STB resulted in less total hemidiaphragmatic paralysis (figure 2), less subjective dyspnea (figure 3) and lower incidence of Horner's Syndrome (RR 0.06; 95% CI 0.01 to 0.32; p < 0.001; I2 = 0%, 3 RCTs, 221 patients). No statistically significant differences were found between the two groups for other outcomes, except for pain score at rest at 24h, which was favorable to STB (MD -0.75; 95% CI -1.35 to -0.15; p = 0.01). However, we should consider the clinical relevance of this