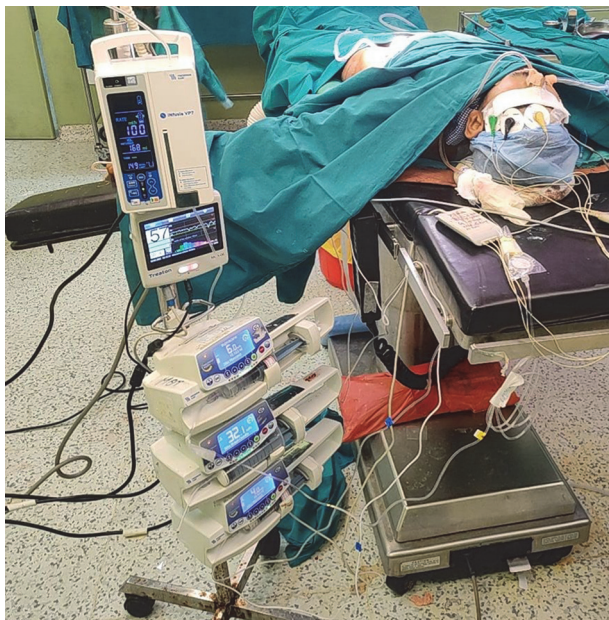


40mcg IV over 10 minutes. The patient was preoxygenated for 3 minutes and later Induced with Inj. Propofol 80mg IV. Once BIS was <60, patient was intubated using 7.0 cuffed endotracheal tube and fixed at 21cm. The endotracheal tube cuff was inflated with 5ml of 1% lignocaine to prevent intubation related complications during extubation process.

Results If BIS>80, Inj. Propofol 20mg IV bolus was given. BIS was maintained around 60 intraoperatively. Patient was maintained intraoperatively by O₂: Air = 0.51:2l. Inj. Propofol at 160 to 320mg/hr, Inj. Dexmedetomidine at 10 to 20mcg/hr and epidural infusion was maintained with 4 to 6ml of 0.25% bupivacaine. Post-Operative patient was extubated the next day in ICU.



Abstract #35931 Figure 1 Maintenance of myasthenia gravis patient

Conclusions Airway block helped in successful management of myasthenia gravis patient without skeletal muscle relaxant for successful surgery.

#36476 CERVICAL SYMPATHETIC CHAIN/'STELLATE GANGLION' BLOCK UNDER ULTRASOUND GUIDANCE TO TREAT 15 YEAR OLD OLFACTORY DYSFUNCTION/ANOSMIA

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Application for ESRA Abstract Prizes: I don't wish to apply for the ESRA Prizes

Background and Aims Olfactory dysfunction/anosmia is a very difficult condition to treat and can be debilitating and dangerous for patients. Conventional management produces very poor outcome and cervical sympathetic chain block/'Stellate

ganglion block' (SGB) has shown dramatic effects for some patients. This is a case report of 50 year old male with history of anosmia for 15 years due to diabetes and sinus diseases treated successfully with ultrasound guided cervical sympathetic block.

Methods He had right cervical sympathetic chain block at the level of C6 vertebra using ultrasound guidance (HF linear probe, 50 mm echogenic needle). 5 ml 1% lignocaine was given and left sided block done after 5 days using 0.5% Levo-bupivacaine under strict strict asepsis. Both times he developed Horner's syndrome which is a sign of cervical sympathetic block.

Results He started to get few range of smells after nearly 24 hours post procedure. Second procedure improved the response and the range of smell increased. It is still continuing after 2 months and he is doing smell retraining to improve it further.

Conclusions Olfactory bulb is one part of brain with the ability to regenerate. Sympathetic block is shown to increase the blood flow to olfactory bulb and nerves area promoting regeneration which is the postulated mechanism of return of smell. Cervical sympathetic block/'SGB' block is a relatively simple and safe procedure to do especially under ultrasound guidance which can be used for not only treating various pain conditions, but for many other medical conditions including olfactory dysfunction.

#36101 TRAINING IN PLAN A BLOCKS – A REGIONAL TRAINEE SURVEY AND QUALITY IMPROVEMENT PROJECT

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Background and Aims The importance of regional anaesthesia (RA) training has recently been recognised by changes to the RCoA curriculum. Where previously trainees could finish training without necessarily achieving competency in 'Plan A' blocks, the requirement now is to perform these blocks independently and to manage any complications. We surveyed the confidence of current West Midlands anaesthesia trainees in Plan A blocks and explored what barriers are encountered in their training.

Methods An anonymised survey was emailed to West Midlands anaesthetic trainees recording stage of training, awareness of Plan A blocks, level of experience in these, and barriers to training in RA.

Results A total of 51 trainees responded. Only 62% were aware of the concept of Plan A blocks. Exposure was greatest for upper limb blocks, and was particularly low for rectus sheath and erector spinae blocks. Almost all senior trainees undertaking advanced training in RA were confident performing blocks independently. This contrasts with only 20% of Stage 3, and no Stage 1-2 trainees. The most common barriers to training were 'a lack of frequent opportunities', 'case mix', 'no suitable trainers' and 'insufficient access to formal training'.

Conclusions This survey has highlighted key issues in RA training in this cohort. There is a reassuring improvement in