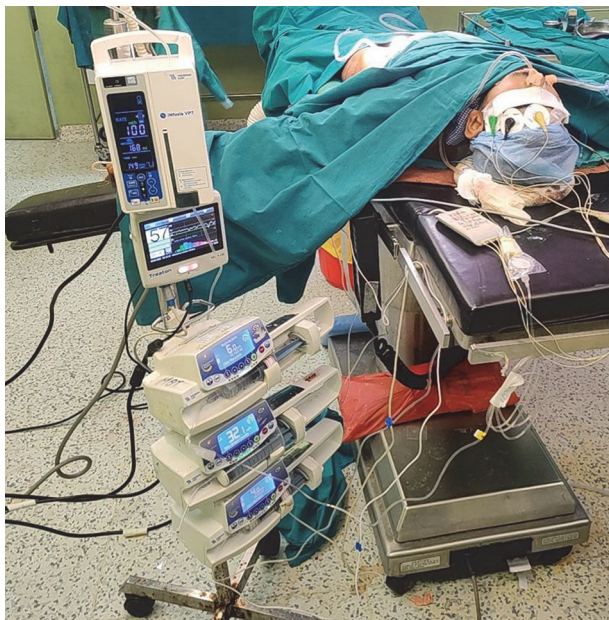


40mcg IV over 10 minutes. The patient was preoxygenated for 3 minutes and later Induced with Inj. Propofol 80mg IV. Once BIS was <60, patient was intubated using 7.0 cuffed endotracheal tube and fixed at 21cm. The endotracheal tube cuff was inflated with 5ml of 1% lignocaine to prevent intubation related 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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Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

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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Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

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

confidence as trainees progress in training, with trainees undertaking advanced training getting more experience and more confidence to practice independently. However, achieving this for all trainees will require focus from trainers within the region including providing more access to training, courses and increasing the frequency of clinical opportunities.

#36356 DIFFERENCE BETWEEN 'PREMATURE' AND 'ADEQUATE' TRANSFUSION- WHY IS IT SO DIFFICULT?

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Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

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

Background and Aims Optimum transfusion trigger for elderly patients undergoing hip fracture repair is still uncertain. During the last decade „patient blood management' (PBM) and its three treatment „pillars' has emerged as a part of surgical patients care. The aim of this study was to evaluate the reason for transfusion in elderly surgical hip fracture patients, with preexisting anemia – strategy addressed to the 3. pillar of PBM.

Methods Elderly patients (age 65 or over) with preexisting anemia (WHO definition) undergoing surgery for hip fracture between February 2020 and December 2022 were retrospectively evaluated. Only patients receiving blood transfusion perioperatively were included in this study: because of hemoglobin level (<80 g/L), sign and symptoms indicative of anemia (physiological trigger), patients' comorbidities, or combination of each. Mercuriali algorithm was used for all patients, calculating tolerated red blood cell loss, (tRRCV), and perioperative red blood cell loss (pRRCV). Patients perioperative data were statistically analyzed.

Results A total 65 anemic patients were included, average age 85 years, 85% female. Patients in group I (40 patients, tRRCV < pRRCV) had lower preoperative hemoglobin (106 ± 8 g/L vs 112 ± 10 g/L), and had higher transfusion index (591 ± 223 vs 335 ± 158 mL) than group II (25 patients, tRRCV

>pRRCV). Physiological trigger was the main reason for transfusion in both groups. There was no statistically significant difference according to reason of transfusion between two groups.

Conclusions Perioperative anemia in elderly patients poses a clinical challenge. Despite intense research to identify an optimal transfusion trigger for patients, larger clinical trials are needed to prove the outcome benefit.

#34666 CASE REPORT: ABLATION OF RENAL TUMOUR IN HIGH BMI PATIENT UNDER SINGLE SHOT PARAVERTEBRAL AND REMIFENTANIL

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Background and Aims Managing patients with multiple comorbidities is an increasingly common requirement of anaesthesiologists. This is compounded by the increasing demand for anaesthesia to be provided outside of the operating theatre. The role of regional anaesthesia and its use in avoiding the general physiological changes associated with general anaesthesia is becoming increasingly apparent.

Methods Our patient is a 60 year old male presenting for radiofrequency ablation of a renal tumour. His medical history was relevant for tuberculosis involving his lungs and pericardium for which he had undergone a right lower lobectomy and pericardiectomy, and Ulcerative Colitis for which he had undergone a subtotal colectomy. His comorbidities included Chronic Obstructive Pulmonary Disease for which he was on 6 litres/minute of portable oxygen, obstructive sleep apnoea requiring CPAP, recurrent chest infections, Atrial fibrillation on Rivaroxaban, Liver Cirrhosis Childs Pugh A, Grade 1 Obesity, Type 2 diabetes, Gout, steroid induced myopathy.

Results We report the use of an ultrasound guided paravertebral block in conjunction with monitored sedation using remifentanyl to facilitate radiofrequency ablation of a low grade clear cell renal tumour. The procedure was tolerated well with satisfactory ablation of the tumor. Mr. EL was discharged the day after his procedure for follow up imaging in 4 months.

Conclusions The use of a regional technique allowed us to avoid the complications of general anaesthesia in this high-risk gentleman, while facilitating the ablation of his renal tumor. Paravertebral blocks serve an increasingly important role in facilitating ablation of solid organ tumours, including lung, liver and kidney, in our institution.

#35788 ACUTE PAIN PROTOCOL FOR SICKLE CELL CRISIS – QUALITY IMPROVEMENT PROJECT

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

Background and Aims Pain from sickle cell crises can be challenging to manage when patients experience intractable pain with high opioid requirements. We aim to decrease average hourly pain score by 20% over first four days of admission and decrease average length of stay by 20% for sickle cell admissions to UTMB by implementing an acute pain protocol for hospitalists and the Acute Pain Service to standardize pain management.

Methods Being devoid of patient identifiable information, this study is exempt from IRB review requirements as per UTMB policy. We conducted a cohort study with a retrospective review of a control group (18 inpatient sickle cell patients)