

Results As the LOS was positive, lidocaine 2% 20ml with sufentanyl 5mcg was injected in fractionated doses associated with aspiration to avoid intravascular injection. The technique was tracked by an ultrasound image. The onset time was short and the efficacy was high.

Conclusions These two case reports come from the anatomical studies of the intercostal space, where some authors discussed the possibility of blocking many nerves with a single injection. A little change in the published technique and the addition of the ultrasound could make it safer.

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#34914 **ANESTHESIA AND POSTOPERATIVE PAIN MANAGEMENT IN HALLUX VALGUS AMBULATORY SURGERY: RETROSPECTIVE OBSERVATIONAL STUDY**

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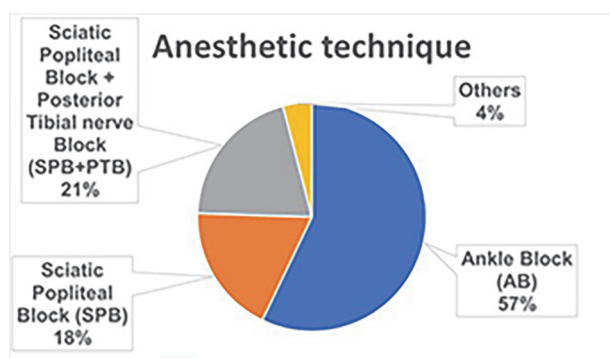
10.1136/rapm-2023-ESRA.501

Please confirm that an ethics committee approval has been applied for or granted: Yes: I'm uploading the Ethics Committee Approval as a PDF file with this abstract submission

Background and Aims Hallux valgus (HV) surgery is associated with severe postoperative pain, requiring an anesthetic-analgesic strategy based on peripheral nerve blocks (PNB). Our goal was to assess the anesthetic strategy and postoperative pain control in HV ambulatory surgery.

Methods A descriptive observational retrospective study was designed and included 49 patients in 2021 at Hospital de la Santa Creu i Sant Pau, Spain. Anesthetic techniques, time to discharge and postoperative pain at 24 hours of surgery were collected. Ethical approval was taken from Institut d'Investigació Biomèdica Sant Pau (IIBSP-HAL-2023-62).

Results The most used anesthetic technique was PNB in 95.92%: Ankle block (AB), sciatic popliteal block (SPB) with posterior tibial nerve block (PTB) and SPB exclusively. Only 6.4% of patients required general anesthesia due to a failed blockade. No patient required opioids as rescue analgesia. The median hospital discharge time was 115 minutes (92.5 min for AB versus 120 min for other PNB), with no statistically significant differences. At discharge, all patients reported NPRS scores of 0. On the day after, 65,3% (n=32) of patients reported NPRS score. Both techniques were effective in achieving mild pain (NPRS 2).



Abstract #34914 Figure 1 Anesthetic technique

Abstract #34914 Table 1 Peripheral nerve blocks

Technique	Local anesthetic	Volume (ml)	Dexamethasone
AB	Ropivacaine 0,75%	20	75%
SPB+PTB	Mepivacaine 1,5% // Ropivacaine 0,5%	15 // 5,5	10%
SPB	Ropivacaine 0,375%	20	33,33%

Abstract #34914 Table 2 NPRS 24h

NPRS 24h	% (n)
<=3	84% (25)
4-6	9.38% (3)
>=7	6.25% (2)

Conclusions The utilization of PNB for HV ambulatory surgery led to favourable analgesic outcomes and low complication rates. The most frequent PNB was the AB (77.5%), with adjuvants added in 57.89% of patients, achieving effective postoperative analgesia without motor block, which should have facilitated earlier discharge. However, our findings suggest that further improvements to our outpatient surgery pathway are needed, as we did not observe differences in discharge times.

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#34261 **FASCIA ILIACA BLOCK VERSUS LUMBAR PLEXUS BLOCK AS ANALGESIA IN HIP SURGERIES: A RETROSPECTIVE COHORT STUDY**

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Background and Aims Although there is no gold standard regimen yet on regional or multimodal pain management for hip patients, some ultrasound-guided peripheral nerve blocks such as the fascia iliaca (FI) and lumbar plexus (LP) blocks were known to provide good analgesia, and to compare the effectiveness and safety of these two was the aim of this study.

Methods This was a retrospective, cohort type of study done through chart review of hip surgery patients at a tertiary care center. The primary endpoint was patient reported pain scores using numeric rating scale (NRS) at post-anesthesia care unit (PACU) and within 24 hours post-block.

Results From the 50 patients who underwent hip surgery, 36 and 14 patients were given ultrasound-guided FI and LP

blocks, respectively. The clinical outcomes such as post-operative pain, length of stay at the PACU, and adverse events were comparable ($p > 0.05$) between the two groups. Overall, the post-operative pain score was graded as zero by the majority of patients at zero minutes up to 120 minutes, 92% and 88% respectively. A pain score of 6 to 10 (severe pain) was noted by 1 to 2 patients up to 60 minutes post-operative. There were no adverse events reported, and PACU stay was at a median of 2 hours, shortest was at 2 hours and longest was at 5 hours, which was noted in the FI group.

Conclusions Fascia iliaca and lumbar plexus blocks were both effective and safe in providing post-operative pain control in hip surgery patients.

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#36490 CASE REPORT: BILATERAL BRACHIAL PLEXUS BLOCKS FOR BILATERAL UPPER LIMB TRAUMA

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Background and Aims A 75 year old male presented to hospital with traumatic injuries after falling down stairs. He sustained multiple rib fractures, facial fractures and bilateral displaced radial fractures. The patient developed pulmonary contusions and rib fracture pain was managed with multimodal analgesia including an erector spinae plane catheter. He was listed for bilateral distal radial open reduction and internal fixation (ORIF) by trauma surgical team.

Methods Bilateral infraclavicular brachial plexus block performed whilst patient awake in supine position using an 80mm needle in plane with real time ultrasound. Total of 40 ml of 0.375% Bupivacaine used. Sedation was achieved with Propofol target controlled infusion and boluses of midazolam and ketamine. No airway intervention was required, the patient breathed spontaneously throughout.

Results Right and left distal radial ORIF were performed simultaneously with separate surgical teams with pneumatic tourniquets on each arm.

Conclusions In our experience anaesthetists would be hesitant to perform bilateral brachial plexus blocks due to concerns regarding inadvertent phrenic nerve block, local anaesthetic toxicity and perceived patient discomfort with bilateral motor block. We carefully calculated local anaesthesia doses for two blocks as well as considering the contribution of bupivacaine from the erector spinae plane catheter. Ultrasound guided infraclavicular block allowed us to reduce risk of phrenic nerve embarrassment and perform the block comfortably in a supine position with minimal patient movement. In this case regional anaesthesia avoided the perioperative risks of a general anaesthesia in a patient with significant chest trauma, the patient recovered well post-operatively.

#35774 EARLY DISCHARGE AFTER LOWER LEG SURGERY IN POPLITEAL AND SAPHENOUS NERVE BLOCK IN A 95-YEARS OLD PATIENT WITH A RECENT STROKE – A CASE REPORT

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Background and Aims The number of elderly patients presenting for trauma surgery is increasing with the aging population. The perioperative management of the elderly is often complicated by coexisting diseases and polypharmacy which may delay surgical treatment due to preoperative optimization. The anesthetic technique should be guided by the intended surgical procedure, patient preference and comorbidity. Frail elderly patients are at increased risk for postoperative complications, cognitive impairment, and longer hospital stays.

Methods A 95-years old female had unstable fracture after external fixation of tibia and fibula, due to trans calcaneal pin instability. She was scheduled for replacement of external delta frame fixator with supracutaneous locking plate but had an ischemic stroke six days after the first surgery. Six weeks after the stroke and partial recovery of left-sided hemiparesis, the extraction of delta frame and supracutaneous plate fixation has been performed in ultrasound-guided popliteal nerve block combined with a saphenous nerve block, with 0.75% ropivacaine.



Abstract #35774 Figure 1 Delta frame, external fixation, on right lower leg.