Abstract #35774 Figure 2  Radiograph of right lower leg with supracutaneous plate

Abstract #35774 Figure 3  Supracutaneous plate on right lower leg

Results  A small dose of ketamine, 15 milligrams, was administered during the surgical procedure in the peripheral nerve block as the patient indicated slight pain at the skin incision. Neither extra sedation nor analgesics were required during the surgery nor for ten hours following. The patient was pleased with the painless treatment and showed no signs of cognitive impairment, enabling safe discharge the following day. The patient is routinely going to surgical check-ups six months following the surgery.

Conclusions  Peripheral nerve block should be considered where feasible in the primary approach to anesthesia and analgesia in the elderly patient.

#34089  ERECTOR SPINAE PLANE (ESP) BLOCK FOR ENDOSCOPIC RETROPERITONEAL ADRENALECTOMY: A CASE SERIES

1Shao Hong Neoh*, 2Wee-Sen Choo. 1Singapore, Singapore; 2Anaesthesiology, National University Health Systems, Singapore, Singapore

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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 ESP block is an interfascial plane block first described in 2016 in the management of thoracic neuropathic pain. Since then, it has found use as an analgesic option in various settings including cardiac and spine surgeries. In this case series, we describe the application of an ESP block in two patients undergoing endoscopic retroperitoneal adrenalectomy.

Methods  We conducted these ESP blocks as part of multimodal analgesia in conjunction with general anaesthesia. 25mls of 0.5% Ropivacaine was administered for both cases in the erector spinae plane in conjunction with general anaesthesia. This was conducted at the level of the T9 Transverse Process in Patient 1 and T12 Transverse Process in Patient 2.

Results  The use of an ESP block provided satisfactory analgesia with a reported NPRS of 5 out of 10 with 90% satisfaction for our first patient on POD 1. Additionally, our second patient reported no pain at rest and mild pain on movement with 90% satisfaction for pain relief on POD 1. Both patients required 5mg of oxycodone cumulatively in the intra and post-operative period. Both patients required no additional opioids on the general ward and were discharged on POD1.

Conclusions  The use of ESP blockade can be considered as an analgesic option in conjunction with multimodal analgesia for endoscopic retroperitoneal adrenalectomy surgery. This potentially allows for decreased opioid usage and reduction of its associated side effects. The use of such a technique to decrease incidence of chronic post-surgical pain (CPSP) in these patients remains to be studied.

#35947  NOVEL SALINE INJECTION TECHNIQUE FOR THE REVERSAL OF THE CONTINUOUS COSTOCLAVICULAR BLOCK

Hyein Lee*, Seunguk Bang. Daejeon St. Mary's Hospital, The Catholic University of Korea, Daejeon, Korea

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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

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

Background and Aims  Although regional anesthesia provides prolonged postoperative analgesia, there is no suitable method that can facilitate early reversal of the blockade until the duration of action of the local anesthetic has elapsed. A large
quantity of saline is used to reverse the central neuraxial block. However, to the best of our knowledge, a few study has reported a method for reversing nerve blockade in peripheral nerve blocks.

**Methods** A 75-year-old man underwent right shoulder rotator cuff repair under general anesthesia. A continuous costoclavicular block was administered for postoperative analgesia. The postoperative pain was well-controlled and the pain score was 0 on the VAS. However, he was unable to moving his arm with absent proprioception, which showed signs of complete anesthesia. Hence, we injected a small amount of saline under ultrasound guidance to confirm the pattern of spread and the absence of nerve swelling due to injection. There were no signs of needle- and catheter-induced nerve damage. Then, we decided to stop the PCA for neurological examination to rule out surgical factor. However, the patient already could move his arm and complained of pain at that time.

**Results** Unexpected reversal to normal sensory and motor function was observed within approximately 15 minutes after the injection of 15mL of saline.

**Conclusions** In conclusion, we observed a dramatic reversal of sensory and motor nerve blockade within a short time following 0.9% saline injection after a costoclavicular block. Our findings suggest that saline injection can be used to reverse the local anesthesia induced by the costoclavicular block.

Attachment IRB Approval.pdf

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**Abstract #35947** Figure 1 Ultrasound image of continuous costoclavicular block. AA: Axillary artery, AV: Axillary vein, BP: Brachial plexus, SC: Subclavius muscle, SA: Serratus anterior muscle, Arrows: catheter

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**Abstract #34330** Figure 1 Left Brachial Plexus after 12 hours following Supraclavicular Nerve Block

**Conclusions** The recurrent laryngeal nerve (RLN) block is common following an interscalene block, but is quite unusual after a SCN block. RLN block has been reported in 1.3% of cases but almost exclusively in right SCN block (Gupta, et.al). Hoarseness after left SCN block is attributable to the blockade of fibers of RLN in the left vagus nerve, where the drug deposited moved medially to the left subclavian artery where the vagus nerve sits in proximity.

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**Abstract #35649** BILATERAL INTERSCALENIC BLOCK: YET A CONTRAINDICATION?

**Conclusions** The anesthetic plan for this patient was a left supraclavicular nerve (SCN) block, to which the patient consented. After aseptic technique, an in-plane ultrasound-guided left supraclavicular block was performed using high-frequency linear transducer above the middle third of the clavicle. A total of 25 ml of Ropivacaine 0.25% with dexamethasone 8mg was injected.

**Methods** The anesthetic plan for this patient was a left supraclavicular nerve (SCN) block, to which the patient consented. After aseptic technique, an in-plane ultrasound-guided left supraclavicular block was performed using high-frequency linear transducer above the middle third of the clavicle. A total of 25 ml of Ropivacaine 0.25% with dexamethasone 8mg was injected.

**Results** A 23-minute soaking time achieved a surgical anesthesia to the operative site. The patient also complained of hoarseness. His hemodynamic parameters were normal, no desaturation, no difficulty of breathing, and no agitation. The patient was reassured then sedated to a Modified Ramsay Sedation Score of 3. The surgery was completed in 57 minutes. Still, with hoarseness noted. He was pain-free for 12 hours. The hoarseness was resolved as soon as the block diminished.

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**Abstract #34330** Figure 1 Left Brachial Plexus after 12 hours following Supraclavicular Nerve Block

**Conclusions** The recurrent laryngeal nerve (RLN) block is common following an interscalene block, but is quite unusual after a SCN block. RLN block has been reported in 1.3% of cases but almost exclusively in right SCN block (Gupta, et.al). Hoarseness after left SCN block is attributable to the blockade of fibers of RLN in the left vagus nerve, where the drug deposited moved medially to the left subclavian artery where the vagus nerve sits in proximity.