



Abstract #35881 Figure 2 POD6 during hand review

**Methods** A 50-year-old woman presented with post operative stiffness of left ring finger following open reduction and internal fixation of proximal interphalangeal joint fracture. In view of her limited active range of motion, she underwent removal of implants and tenolysis of flexor and extensor tendons under regional anaesthesia with an infraclavicular brachial plexus block. Following surgery, ultrasound guided insertion of median and ulnar nerve catheters at the level of the forearm was performed and continuous infusions of 0.2% Ropivacaine via two balloon infuser pumps was started. The patient was guided on care of outpatient catheters and allowed to self-titrate the infusion rates to maintain analgesia while avoiding excessive motor blockade.

**Results** On post operative day six, she was able to move fingers with minimal pain and oral analgesia and catheters were removed by herself the next day.

**Conclusions** This case highlights the use of ambulatory catheters for post operative analgesia in the outpatient setting to promote early physiotherapy.

### #33932 ERECTOR SPINAE PLANE BLOCK FOR PAIN RELIEF IN THORACIC TRAUMA – CASE REPORT

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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** Rib fractures are common in trauma patients and require effective analgesia to prevent respiratory complications. Regional anaesthetic techniques, such as thoracic epidural or paravertebral block, are often the mainstay of treatment. In the erector spinae plane (ESP) block, by placing the local anesthetic deep to the erector spinae muscle and near the costotransverse foramina, we can achieve effective analgesia.

**Methods** We report a case of a successful ESP block using a continuous technique for analgesia in a 60-year-old trauma patient who presented with multiple left-sided rib fractures from T3-T8. 24 hours post injury the patient complained of severe pain in the left hemithorax and was unable to take a deep breath or cough, despite optimized intravenous analgesia. With the patient in a right lateral decubitus position, a left-sided ultrasound-guided ESP block was conducted at the level of T6. A bolus of 30ml 0,2% ropivacaine produced almost immediate pain relief. An indwelling peripheral nerve block catheter was placed within the ESP under ultrasound guidance. The catheter was secured in place. A continuous infusion of 10 ml/h 0,2% ropivacaine with patient-controlled analgesia boluses of 5mL was initiated.

**Results** In the following days, the patient revealed lower pain scores and greater breathing ability. After 3 days the catheter was removed.

**Conclusions** Fascial plane blocks like the ESP block are technically easier to perform compared with neuraxial and targeted nerve blocks and have fewer serious side-effects. In our case, the presence of unilateral rib fractures made the ESP block an effective alternative to neuraxial or paravertebral procedures.

### #36207 REBOUND PAIN IN ELECTIVE TRAPEZIECTOMY FOLLOWING REGIONAL ANAESTHESIA

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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

**Background and Aims** Rebound pain describes an increase in pain sensation after a peripheral nerve block has receded. Theories suggest rebound pain may be due to inadequate pre-emptive systemic analgesia whilst the block is receding, or hyperalgesia after local anaesthetic. Our centre introduced standardised discharge analgesia regimes for upper limb surgery under regional anaesthesia. We sought to identify whether adequate long-acting analgesia and patient education affected our patients' experience with day case trapeziectomy under regional anaesthesia.

**Methods** Following local department audit/QI committee approval patients undergoing elective trapeziectomy, over a year long period and meeting inclusion criteria were discharged with standardised TTOs including 3 doses of a prolonged release opioid and a patient information leaflet. They were followed up by a qualitative telephone questionnaire at 4-6 weeks. These results were compared with a retrospective interview with patients having been identified as having had a trapeziectomy in the 12 months preceding the introduction of