standardised TTOs. Results were compared using the Chi squared significance test.

**Results** A total of 44 patients met inclusion criteria, 24 pre and 20 post standardisation. Pain scores (p=0.21), and satisfaction (p=0.42) showed no significant difference. Sleep quality trended towards significance (p = 0.067, but significantly fewer patients required to seek further medical help for pain management post discharge (25% vs 0%, p<0.05).

**Conclusions** The introduction of long-acting analgesia and patient information leaflets did not significantly alter the post operative pain scores, patient sleep quality or patient satisfaction. However, significantly fewer patients required to see their healthcare provider for further post discharge analgesia.

**Abstract #35903**

**HIGH VOLUME SUPRA-INGUINAL FASCIA ILIACA BLOCK FOR ANALGESIA AFTER ACETABULAR FRACTURE SURGERY**

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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** Acetabular fractures are commonly associated with severe postoperative pain, and there is currently no shared consensus regarding analgesia compared to hip fractures. The acetabulum is mainly innervated by the lumbar plexus (LP), however the posterior approach to the LP is technically difficult and associated with serious complications of spinal and epidural spread, intravascular injection with local anaesthetic systemic toxicity and retroperitoneal haemorrhage.

**Methods** A 62-years-old male, ASA2, 67kg, underwent open reduction internal fixation of double column acetabular fracture. Supra-inguinal fascia iliaca (FI) compartment block was performed after induction of general anaesthesia. The ultrasound probe was positioned in a parasagittal plane inferomedial to the anterior superior iliac spine, the iliacus muscle, internal oblique and sartorius forming the bow-tie sign and the deep circumflex iliac artery were identified. Needle was introduced in-plane in caudal to cranial direction, 40ml 0.3% ropivacaine was given with hydrodissection and cranial spread of local anaesthetic deep to the fascia iliaca into the iliac fossa visualised.

**Results** In the first 48 hours postoperatively, patient reported a numerical rating scale for pain < 4. Bromage score was 0. Multimodal analgesia was initiated with paracetamol, etoricoxib, sustained-release oxycodone/naloxone and oxycodone for breakthrough pain. Patient took total 47.5mg oxycodone. Pain control was satisfactory.
Abstract #35903 Figure 3  Anatomical and ultrasound landmarks for supra-inguinal fascia iliaca compartment block (Image used with permission from Source: NYSORA.com)

Conclusions High volume supra-inguinal FI block aims to improve cranial spread of local anaesthesia high in the iliac fossa to consistently block the femoral nerve, lateral femoral cutaneous nerve and obturator nerve which contribute to acetabulum innervation. It is a safe technique that provides effective postoperative analgesia in acetabular fracture surgery.

Abstract #36444 Figure 1  M-mode ultrasonographic imaging of ipsilateral diaphragmatic excursion at the 2nd postoperative hour

ULTRASOUND FOR PATIENT SAFETY DURING WHOLE PERIOPERATIVE PERIOD

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Abstract #36444 Figure 2  M-mode ultrasonographic imaging of ipsilateral diaphragmatic excursion at the 2nd postoperative day

Background and Aims Ultrasonography has recently emerged as one of the most valuable equipment for anesthesiologists during the whole perioperative period. The aim of this report is to describe diagnosis and follow-up of a patient who developed phrenic nerve paralysis during interscalene block performed with nerve stimulator.

Methods A 71-year-old woman with known hypertension was scheduled for surgery for supraspinatus muscle tear. The patient underwent an interscalene block with 25 cc 0.5% bupivacaine using nerve stimulator. The patient was transferred to post anesthesia care unit with a possible diagnosis of phrenic nerve paralysis as the SpO2 value was 88% and needed O2 of 8 L/min. Ultrasonographic examination revealed diaphragmatic paralysis as the excursion was only 1.6 cm (figure 1). During the follow-up the patient’s diaphragm movements recovered and she was transferred to ward with an excursion measured 4.1 cm and SpO2 of 96% in room air (figure 2)

Results Interscalene block is associated with hemidiaphragmatic paralysis as a result of phrenic nerve block[1]. It is usually a benign condition and resolves spontaneously but close monitoring may be needed in some cases. In this case, in addition diagnosing the pathology, ultrasound improved patient safety by enabling real-time diaphragm monitoring.

Conclusions In addition to improving safety during regional anesthesia practice, ultrasonography may also play an important role during management of the complications. [2].

Abstract #35903 Figure 2 Anatomical and ultrasound landmarks for supra-inguinal fascia iliaca compartment block (Image used with permission from Source: NYSORA.com)