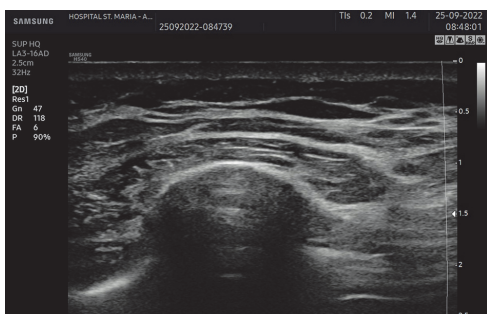


Abstract #35936 Figure 2 External Oblique Intercostal Block



Abstract #35936 Figure 3 External Oblique Intercostal Block

**Conclusions** The EOI plane block shows promising results in targeting upper abdominal wall analgesia, an anatomic region not sufficiently addressed by other fascial plane blocks, such as the subcostal Transversus Abdominis Plane block or the Rectus Sheath block.

### #36086 PATIENT PERCEPTIONS AND RECALL OF THE CONSENT PROCESS FOR REGIONAL ANAESTHESIA WITHIN OUR DEPARTMENT

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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** There are well established procedures for obtaining and documenting informed consent for surgical procedures. Anaesthetic procedures, lack the same standardized approach. This has safety implications for patients and clinicians. We sought to evaluate the patient experience of those who underwent regional anaesthesia (RA) within our department.

**Methods** Following approval from our audit committee, we conducted a twelve-part telephone survey with thirty patients regarding their experience of RA. The survey explored the circumstances under which patients were consented, and their recall of the information provided.

**Results** Of the total number of patients interviewed (n=30), seventy percent (21) believed the NB was compulsory. Sixty percent (18) could not recall any of the possible advantages of receiving a NB and eighty percent (24) could not recall any risks. Sixty-six percent (20) of patients were consented for a NB in the holding bay. Sixteen percent (5) were consented in the induction room. Sixty percent (20) of patients said they would have valued written information regarding the NB. A majority (17) felt they did not have adequate time to consider the NB. Currently there is no formalized process that exists within our department for documentation of the risks and benefits discussed with patients. The practise of which can therefore vary greatly amongst practitioners.

**Conclusions** Our results demonstrate a paucity of information that is either delivered to, or retained by, our patients with regards to receiving RA. We aim to distribute a Patient information leaflet to better achieve informed consent from our patients.

### #35958 NERVE BLOCK OR DOPPLER SIGNAL? WHICH ONE COMES FIRST?

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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** Proper pain management in patients undergoing Anterolateral Tigh (ALT) flap surgery is crucial to minimize early postoperative complications. We present a case of a 58-year-old male admitted for partial pelviglossectomy, mandibulectomy and ALT of the left limb, who received both limbs a femoral nerve block due to insufficient Doppler flowmetry on the limb first chosen by the surgeons. We aim to demonstrate that a pre-emptively femoral nerve block can be part of a multimodal analgesic strategy in these patients and that a second non-planned nerve block can be safely performed if the maximum dose of local anesthetic is taken into consideration.

**Methods** A total intravenous anesthesia with propofol and remifentanyl was induced and a single-shot, ultrasound-guided, right and left femoral nerve blocks were performed using 15 ml of 0,75% ropivacaine on each side. A total of 30ml (225 mg) was administered – a safe dose of ropivacaine for an 80kg patient. The maintenance dose of remifentanyl was low (up to less than 0,05-0,10 mcg/kg/min) and analgesia was complemented with ketorolac 30mg, paracetamol 1g and morphine 2mg.

**Results** There were no signs of local anesthetic systemic toxicity (LAST) and the patient was admitted to the post-anesthetic care unit after 10h of surgery without pain in the flap area, 0/10 (numerical rating scale pain) at rest and movement. Pain at rest was only reported more than 24h after the block.

**Conclusions** This case enhances the importance of performing vascular Doppler signals before anesthetic nerve blocks to avoid unnecessary blocks and risk for LAST.