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 commonly occur in trauma patients and cause morbidity and mortality due to secondary pulmonary complications. This study aims to assess if patients presenting with rib fractures are managed according to the Countess of Chester hospital (COCH) rib fracture guidelines and outcomes.

**Methods**
Data was collected on patients >18 years of age presenting to COCH with rib fractures between April 2022 and April 2023. Outcomes measured were rates of rib fracture score (RFS) calculation, regional anaesthetic (RA) block rates, LOS (length of stay), intensive treatment unit (ITU) admission and mortality rates.

**Results**
A total of 48 patients were included in the study. 25% had RFS calculated during their stay. Totally, 20.83% of patients had a RA block attempted however only 30.77% of patients with an RFS > 9 had a RA block attempted. 18.75% required ITU admission - these patients had an average LOS of 10.11 days in ITU and 24.5 days overall. 83.33% were required ITU admission - these patients had an average LOS of 10.11 days in ITU and 24.5 days overall. 83.33% were discharged home, 8.33% died and 8.33% were transferred elsewhere.

**Conclusions**
75% of patients presenting to COCH with rib fracture did not have a RFS calculated and therefore were not considered for RA blocks. In addition, a significant proportion of anaesthetists were untrained in nerve blocks/nerve catheters for rib fractures. We are now administering ESPB catheters and are administering education to nursing staff to improve rates of RFS calculation and improve risk stratification of these patients. We anticipate these interventions to reduce morbidity, mortality and subsequent LOS, which we will re-audit in 1 years' time.

Attachment: ESRA Ethics letter.pdf
Peripheral vascular disease and prior above knee amputations. Peripheral nerve block serves as a good alternative for both intraoperative and postoperative analgesia. This case report aims to describe the role of suprainguinal fascia iliaca block for hip disarticulation surgery.

Methods A 54-year-old male, presented with large inguinal ulcer and stump ulcer following above knee amputation due to peripheral arterial disease. He was still on both oral clopidogrel and cilostazol. General anesthesia was conducted with fentanyl and ketamine as induction agents then central line was inserted. Suprainguinal fascia iliaca block was attempted with 40 mls of ropivacaine 0.375%; then continuous catheter was inserted after successful single shot block. Intraoperatively, hemodynamic was stable and no additional opioid was administered. Postoperative pain management included continuous ropivacaine 0.2% 10 ml/hour, oral paracetamol, and gabapentin. Patient reported minimal pain at 24 hours postoperative.

Results Hip disarticulation surgery is relatively rare procedure with challenging anesthesia management, especially when it is delivered in high-risk patients. Peripheral nerve block, including suprainguinal fascia iliaca block, may provide beneficial alternative for both intraoperative and postoperative analgesia.

Conclusions Suprainguinal fascia iliaca block serves as relatively simple and safe peripheral nerve block for hip disarticulation surgery in high-risk patients.

Abstract #36338 Figure 1 Suprainguinal fascia iliaca block

Abstract #36338 Figure 2 Clinical pictures of hip disarticulation surgery due to stump and inguinal ulcer following above knee amputation

Results Awake craniotomy is multidisciplinary teamwork, and the anesthesiologist should know for various purposes, scalp blockage, and forward referral management.