

**#36077 REGIONAL ANESTHESIA TRENDS AND INCIDENCE OF LAST IN US ACADEMIC HOSPITAL OVER 15 YEARS**Anil Marian\*. *Department of Anesthesia, University of Iowa, Iowa City, USA*

10.1136/rapm-2023-ESRA.566

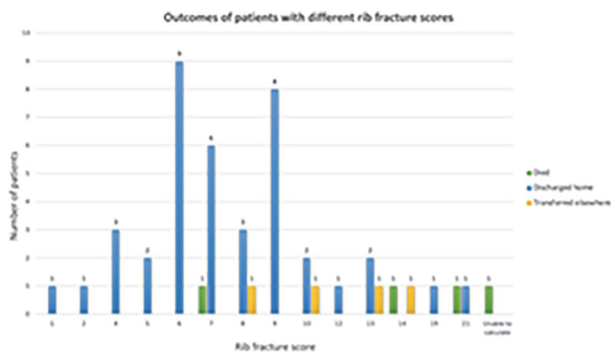
**Please confirm that an ethics committee approval has been applied for or granted:** Not relevant (see information at the bottom of this page)

**Application for ESRA Abstract Prizes:** I apply as an Anesthesiologist (Aged 35 years old or less)

**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 rates 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 discharged home, 8.33% died and 8.33% were transferred elsewhere.



**Abstract #35876 Figure 1** Graph showing outcomes of patients with different rib fracture scores

**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 catheter training 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 year's time.

Attachment: ESRA Ethics letter.pdf

**#34412 USE OF TRIPLE MONITORING IN REGIONAL ANAESTHESIA**

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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** Triple monitoring (TM) involves the use of a nerve stimulator, ultrasound imaging and a pressure limiting device (PLD), particularly when performing plexus blocks and peripheral nerve blocks (PNB). Alongside performing regional anaesthesia (RA) in awake patients, TM is seen as the gold standard in monitoring. The aim of this study was to determine how anaesthetists monitor their administration of RA.

**Methods** Fifty peripheral nerve blocks were audited for monitoring standards. Documentation for each block was retrospectively analysed. In addition, a survey was sent to all anaesthetists to gather current monitoring standards used in regional anaesthesia, and knowledge regarding how to use pressure limiting devices and nerve stimulators.

**Results** One peripheral nerve block (2%) was performed using a PLD. In 22% of cases a nerve stimulator was used in addition to ultrasound imaging. Ultrasound imaging was used in all cases. The survey had 29 respondents. Twelve percent claimed to use TM whenever performing a PNB. One third of respondents admitted to never using a nerve stimulator when performing regional anaesthesia. Only 32% of respondents were aware that a response to stimulation seen at 0.4mA should raise concerns regarding the possibility of intraneural injection.

**Conclusions** Routine follow up after RA is not seen in most anaesthetic departments. The presence of nerve injury as a result of RA may also be over-reported, since the incidence may be confounded by an injury caused surgically. In the absence of a formalised follow up pathway, we should be aiming to follow best practice and use TM when performing PNBs.

**#36338 SUPRAINGUINAL FASCIA ILIACA BLOCK FOR HIP DISARTICULATION SURGERY IN A HIGH RISK PATIENT: A CASE REPORT**

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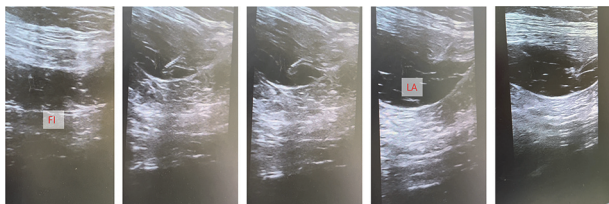
**Please confirm that an ethics committee approval has been applied for or granted:** Not relevant (see information at the bottom of this page)

**Background and Aims** Hip disarticulation is a radical lower extremity amputation performed as a last resort in life-preserving circumstances. This procedure is often done for patients with complex medical conditions, including concomitant

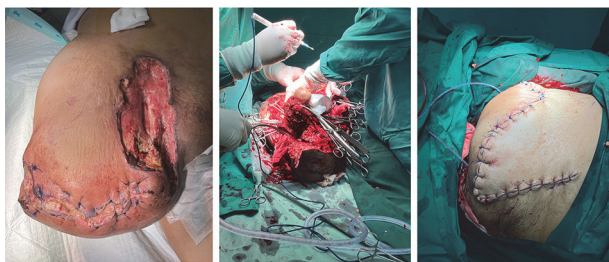
peripheral vascular disease and prior above knee amputations. Peripheral nerve block serves as a good alternative for both intraoperative and postoperative analgesia. This case report aims to describe the role of suprainguinal fascia iliaca block for hip disarticulation surgery.

**Methods** A 54-year-old male, presented with large inguinal ulcer and stump ulcer following above knee amputation due to peripheral arterial disease. Patient had history of chronic renal disease on routine dialysis, congestive heart failure with low ejection fraction, diabetes mellitus, and valvular heart problem. 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.



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

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

**#34467 AWAKE CRANIOTOMY WITH SLEEP-AWAKE-AWAKE TECHNIQUE**

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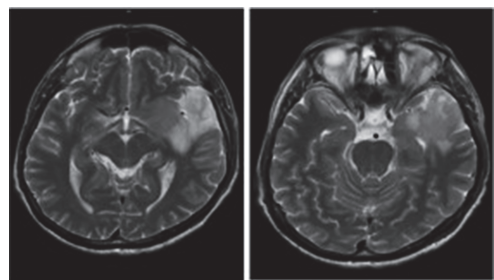
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Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

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

**Background and Aims** The goal of case report is the management of awake craniotomy with sleep-awake-awake technique. An awake craniotomy is a surgical procedure in which patient is deliberately kept awake during whole surgical process or a portion of surgery.

**Methods** The patient was a 49-year-old male; MRI revealed a 42x38 mm glial tumor in the temporal region, close to Broca area, in the structures of the neurosurgery clinic with a complaint of headache. A craniotomy with scalp block was planned for the patient. Consent was obtained after preoperative information was given. Standard anesthesia monitoring (ASA) was performed on the patient. We planned the sleep-awake-awake technique in awake craniotomy. In induction, 2.5mg/kg of propofol, 1.5mcg/kg of fentanyl and 1mg/kg of lidocaine were administered. A supraglottic airway device, I-gel, is inserted. Then, scalp block was performed with 0.5% bupivacaine. Neurosurgeon applied Mayfield pine. As neurosurgeon approached where the tumor was located, the stage of awakening the birth was started. Before these steps, a loading dose of dexmedetomidine 1mcg/kg was given as a 15-minute infusion in 100cc fluid, and 0.2mcg/kg/hour was switched to maintenance. Remifentanyl and sevoflurane are reduced and turned off after 15minutes. The patient whose spontaneous breathing started was awakened, and i-gel laryngeal mask was removed. The patient was talked to every 3-5 minutes until the tumor area was reached and controlled by starting the engine. The patient would talk long enough to answer the questions.



Abstract #34467 Figure 1 Patient MRI

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

**#36481 COMBINED US-GUIDED ERECTOR SPINAE PLANE BLOCK (ESP) + PARASTERNAL BLOCK (PSB): NEW PERSPECTIVES IN OPIOID-FREE ANESTHESIA FOR ONCOLOGICAL MAJOR BREAST SURGERY**

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