Abstract #36322 Figure 2 Local anesthetic consumption (volume in mL)

Conclusions An institutional protocol facilitates adequate continuous improvement. An organized APS and stakeholders’ education are crucial for implementation. Pain control and patient satisfaction were good. Future adjustments to the protocol might decrease adverse events.

#35897 CONTINUOUS BILATERAL ERECTOR SPINAE PLANE BLOCK PROVIDES EFFECTIVE POSTOPERATIVE ANALGESIA AFTER OPEN UPPER ABDOMINAL SURGERY, A CASE SERIES 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 Managing postoperative pain after an open hepatobiliary surgery often presents a challenge. Use of regional anesthetic techniques is common to reduce opioid consumption and its associated side effects. Thoracic epidural analgesia is considered to be the gold standard for this type of surgery, however, it might be contraindicated due to abnormal coagulation, patient refusal, etc. In this study we evaluated the efficacy of continuous bilateral erector spinae block (ESPB) in this setting.

Methods ESPB was performed in 10 adult patients scheduled for open hepatobiliary surgery in whom thoracic epidural was contraindicated due to abnormal coagulation profile or patient refusal. Procedures included Liver-Lobectomy, Hepato-pancreato-biliary, Whipple and exploratory laparotomy. ESP catheters were inserted under US guidance at the level of T5-T6. At the conclusion of surgery, patients received a bolus of 10ml of 0.25% bupivacaine into each ESP catheter followed by a continuous infusion of 0.1% bupivacaine at 12-16mL/h into both catheters. Patients also received non-opioids around the clock for multimodal pain control. We used the maximal VAS score in every 8 hours for the whole duration of infusion which varied and opioid consumption was monitored.

Results Patient demographics, type of surgery, contraindication for thoracic epidural, VAS pain scores taken, 48 postoperative hour opioid consumption as well as duration of ESP are shown in table 1. All patients had successful placement of ESP catheters, no complications were noted. Pain scores were markedly low as well as opioid requirement.

Conclusions Continuous ESPB is a feasible and effective technique for providing analgesia following major open abdominal surgery.

#33548 UTILIZING HIGH DOSE KETAMINE FOR THE TREATMENT OF REFRACTORY, POSTOPERATIVE, PHANTOM LIMB PAIN FOLLOWING TOTAL SHOULDER WITH PROXIMAL HUMERAL REPLACEMENT FOR TRANSDERMAL OSSOEINTEGRATION 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)

Background and Aims Although several studies have demonstrated efficacy of low-dose intravenous ketamine infusions in the perioperative period, there is little to no research investigating the use of high dose ketamine boluses for phantom limb during the acute postoperative period. This case demonstrates the success use of high dose ketamine to alleviate acute, postoperative, phantom limb pain following electrode implantation and total shoulder with proximal humeral replacement for transdermal osseointegration, after failing all other traditional postoperative phantom limb pain regimens.

Methods Direct patient care as well as retrospective chart review.

Results The patient was extubated in the OR and admitted to the ICU postoperatively, for pain control and started on the following pain regimen by the acute pain service: Ketamine gtt at 0.3mg/kg/hr, Subutex 8mg TID, Robaxin 500mg QID, Acetaminophen 1g TID, Lyrica 75mg TID, and IV Dilaudid 0.5 mg q3H PRN for breakthrough. Over the course of the next eight days patient also received daily IV ketamine boluses by a Physician, in 20mg increments, every 10 minutes for up to 5 doses, titrated to effect. The patient received between 60-100 mg of ketamine total during each ‘bolus session’ which occurred twice a day.
Conclusions This case contributes to the experimental evidence that high dose ketamine can be used safely to achieve analgesia for refractory, phantom limb pain during the acute, postoperative period. High dose ketamine can be incredibly effective in achieving analgesia in refractory, acute, postoperative phantom limb pain.

#35824  UNEXPECTED FOOT DROP AFTER PROXIMAL IPACK BLOCK

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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 In our institution, a common practice for providing motor-sparing analgesia after total knee replacement (TKR) is by combining the distal IPACK with adductor canal block. These blocks are typically administered preoperatively after spinal anesthesia to enable pain-free early exercise or deambulation as the neuraxial block wears off. However, in this case report, we describe an inadvertent sciatic block following proximal IPACK block.

Methods Informed consent for publication was obtained. A 69-year-old woman scheduled for TKR, was admitted to the preoperative room with delay. Since the patient arrived late, we decided to proceed with spinal anesthesia and surgery, postponing the analgesic blocks to the recovery area. In order to avoid dressing manipulation and to maintain distance from the prosthesis, we performed the IPACK block postoperatively using the proximal technique, approximately two fingers above the patella in supine position. We injected 20 ml of 0.5% ropivacaine with dexamethasone 4 mg between the popliteal vessels and the femur.

Results The first evaluation was postponed to the following morning since it was late afternoon when the block was performed. The patient presented with complete sensory and motor block below the knee, which resolved completely about 18 hours after the block.

Conclusions Proximal approach to IPACK may increase the risk of local anesthetic spreading toward the sciatic nerve and subsequent motor block. Therefore, we recommend performing this block with nerve stimulator or to chose alternative analgesic techniques for the posterior capsule of the knee, unless a clear US real-time visualization of the nerve structures during injection is possible.

#36316  TAP-BLOCK AS A DIAGNOSTIC AND MONITORING TOOL IN ACUTE SURGICAL ABDOMEN: 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)

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

Background and Aims The transversus abdominis plane (TAP) block is a regional technique for anterolateral abdominal wall analgesia. It is widely used for postsurgical acute pain management, in the context of a multimodal opioid-sparing analgesia. The cornerstone of major abdominal surgery pain management is continuous epidural analgesia. However, especially in the ICU environment, the insertion of an epidural catheter, in addition to being affected by the coagulative arrangement, could be contraindicated by antiaggregation or anticoagulation therapy. It also required advanced technical skills. Moreover, TAP block presented fewer contraindication and it is a rather simple procedure with a shallow learning curve ant it provides long-lasting analgesia.

Abstract #35824 Figure 1 Proximal IPACK block simulation: F = femur shaft; A = popliteal artery; SN = possible location of sciatic nerve. The technique does not permit optimal visualization and require the needle to point an area at risk for nerve involvement. Nerve stimulation is recommended

Abstract #36316 Figure 1 Pelvic CT scan