Conclusions Consistently, the ON displayed staining when employing a subpectineal approach, located caudal to the superior pubic ramus and cranial to the obturator external muscle, in close proximity to the obturator membrane.

OP051 EFFECT OF DEXAMETHASONE AS AN ADJUVANT TO BUPIVACAINE FOR ULTRASOUND- GUIDED AXILLARY PLEXUS BLOCK: A RANDOMIZED, DOUBLE-BLINDED PROSPECTIVE STUDY

[1,2]Hossein Khoshrang*, [3,4]Mohammad Haghighi, [5]Mehran Soleymanha, [4]Saeed Hemati, [6]Firoozeh Khalili, [7]Mahin Tayefe. *[1]Anesthesia department,school of medicine, Guilan University of Medical Sciences, Rasht, Islamic Republic of Iran; [2]Anesthesia Research Center, Alzahra hospital,Anesthesia department,school of medicine, Guilan University of Medical Sciences, Rasht, Islamic Republic of Iran; [3]Anesthesia department, Guilan University of Medical Sciences, Rasht, Islamic Republic of Iran; [4]Anesthesia Research Center, Guilan University of Medical Sciences, Rasht, Islamic Republic of Iran; [5]orthopdic department, Guilan University of Medical Sciences, Rasht, Islamic Republic of Iran; [6]Razi Hospital, Guilan University of Medical Sciences, Rasht, Islamic Republic of Iran; [7]Anesthesia Research Center, Alzahra hos[ital, Guilan University of Medical Sciences, Rasht, Islamic Republic of Iran*

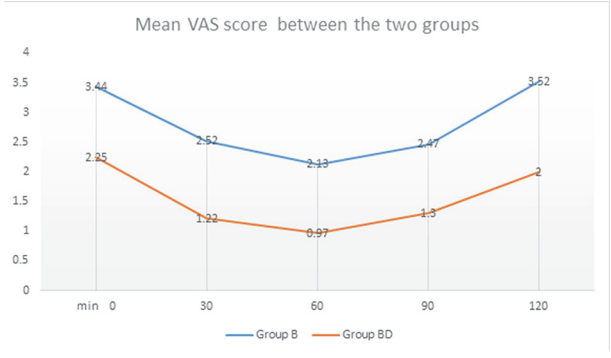
10.1136/rapm-2023-ESRA.51

Please confirm that an ethics committee approval has been applied for or granted: Yes: I'm uploading the Ethics Committee Approval as a PDF file with this abstract submission

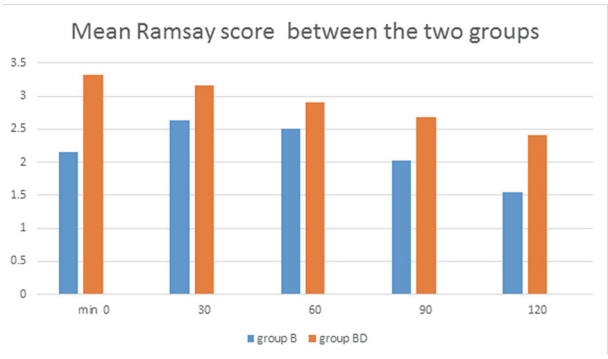
Application for ESRA Abstract Prizes: I don't wish to apply for the ESRA Prizes

Background and Aims In this prospective study, the effect of adding dexamethasone to bupivacaine on the quality of axillary block under ultrasound guidance was evaluated

Methods 72 patients with ASA class I, II and over 18 years of age who are candidates for elective forearm surgery under axillary plexus block, in random blocks prepared from the computer system in two groups: group BD: 30 ml bupivacaine 0.25% with 2 ml dexamethasone (n=36) and group B: 30 ml bupivacaine 0.25% with 2 ml distilled water (n=36). To evaluate the level of sensory and motor block, respectively Pinprick test and Modified Bromage Scale were used, and VAS score and Ramsay score were used to evaluate pain intensity and degree of sedation, respectively. The collected data were analyzed through SPSS V.24 software and the significance level was also considered for P<0.05 values.



Abstract OP051 Figure 1 The mean changes in pain intensity according to the Visual Analogue Scale (VAS) after the axillary plexus block in group BD (bupivacaine 0.25% with dexamethasone) and group B (bupivacaine 0.25% with distilled water)



Abstract OP051 Figure 2 The mean changes in sedation degree according to the Ramsay Sedation Scale (RSS) after the axillary plexus block in group BD (bupivacaine 0.25% with dexamethasone) and group B (bupivacaine 0.25% with distilled water)

Results there was a statistically significant difference between the average sensory (P<0.0001) and motor (P<0.0001) onset time between the two groups, and it was shorter in group BD than in the group B. There was a statistically significant difference between the average duration of sensory and motor block (P<0.0001) and intensity of sensory block (P<0.0001) and motor (P=0.002) in the two groups. The changes in the degree of sedation in the studied time periods after the start of the block in the bubivacaine and dexamethasone group were more than in the group without dexamethasone (P<0.0001).

Conclusions Adding dexamethasone to bupivacaine is effective in prolonging the axillary block time and reducing pain after surgery

OP052 INTERTRANSVERSE PROCESS BLOCK AT THE RETRO-SCTL SPACE: EVALUATION OF INJECTATE SPREAD USING MRI AND SENSORY BLOCKADE IN HEALTHY VOLUNTEERS

[1]Pawinee Pangthipampai, [2]Palanan Siriwanarangsun, [3]Jatuporn Pakpirom, [4]Ranjith Kumar Sivakumar*, [5]Manoj Kumar Karmakar. *[1]Department of Anesthesiology,, Mahidol University, Bangkok, Thailand; [2]Department of Radiology,, Mahidol University, Bangkok, Thailand; [3]Department of Anesthesiology, Prince of Songkla University, Hat Yai, Thailand; [4]Anaesthesia and Intensive Care, The Chinese University of Hong Kong, Shatin, New Territories, Hong Kong; [5]Anaesthesia and Intensive Care, The Chinese University of Hong Kong, Shatin, Hong Kong*

10.1136/rapm-2023-ESRA.52

Please confirm that an ethics committee approval has been applied for or granted: Yes: I'm uploading the Ethics Committee Approval as a PDF file with this abstract submission

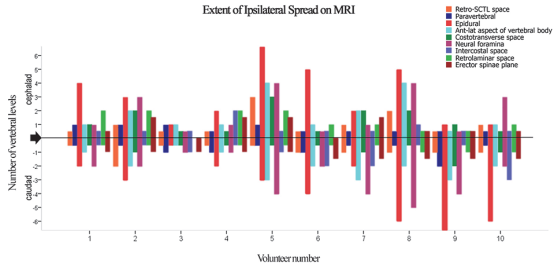
Application for ESRA Abstract Prizes: I apply as a Trainee/Resident/Fellow (no age limit)

Background and Aims This study evaluated the spread of injectate and sensory blockade after an ultrasound-guided (USG) intertransverse process block (ITPB) at the retro superior costotransverse ligament (SCTL) space.

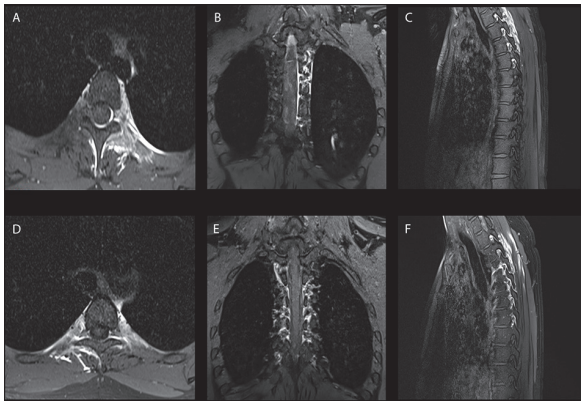
Methods After ethical approval and informed consent, 10 healthy volunteers received an USG ITPB at the retro-SCTL space (T4-T5 level), using a mixture of 10 ml 0.5% bupivacaine with 0.5 ml gadolinium. At 15 minutes, they underwent a T1-weighted MRI of the thorax. Loss of sensation to cold

was assessed at 15 and 60 minutes, and then hourly until 5-hours, after the block. Physical spread of injectate on the MRI and loss of sensation to cold over the thorax were the primary and secondary outcomes, respectively.

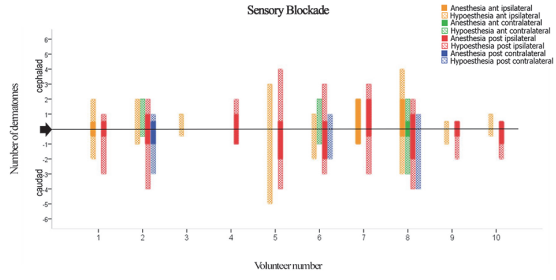
Results The injectate spread to the ipsilateral paravertebral space, neural foramina, epidural space, sympathetic chain, costotransverse space, intercostal space and erector spinae plane in all volunteers, but the extent of craniocaudal spread was variable (figure 3).



Abstract OP052 Figure 1 Ipsilateral spread of an injectate to the various anatomical sites (as assessed on MRI) after a single-level ITPB at the retro-SCTL space. ITPB indicates intertransverse process block; SCTL, superior costotransverse ligament



Abstract OP052 Figure 2 Injectate spread to the various anatomical sites (as seen on MRI) after a single-level ITPB at the retro-SCTL space. MRI images from volunteer 1 (A to C) shows predominantly unilateral spread whereas volunteer 2 (D to F) demonstrates significant bilateral spread. ITPB indicates intertransverse process block; SCTL, Superior costotransverse ligament



Abstract OP052 Figure 3 Number of ipsilateral and contralateral anesthetised (sensory score 0/2) and hypoaesthetic (sensory score 1/2) dermatomes over the anterior and posterior thorax after a single-level ITPB at the retro-SCTL space. ITPB indicates intertransverse process block; SCTL, superior costotransverse ligament

Conclusions An ITPB at the retro-SCTL space consistently spreads to the ipsilateral paravertebral space, neural foramina, epidural space, sympathetic chain, costotransverse space, and intercostal space but produces ipsilateral sensory blockade that is variable and wider over the posterior, than anterior, thorax.

Postoperative pain management – Free papers 7

OP053 CONTINUOUS PERIPHERAL NERVE BLOCKS IN PATIENTS WITH PROXIMAL FEMUR FRACTURE: A PROSPECTIVE, RANDOMIZED COMPARISON OF THREE TECHNIQUES

[1]Nidhi Bhatia*, [2]Kajal Jain, [2]Jeetinder Makkar, [2]Vikas Saini, [2]Uttam Chand Saini. *[1]PGIMER, Chandigarh, India; [2]Doctor, PGIMER, Chandigarh, India*

10.1136/rapm-2023-ESRA.53

Please confirm that an ethics committee approval has been applied for or granted: Yes: I'm uploading the Ethics Committee Approval as a PDF file with this abstract submission

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

Background and Aims Peripheral nerve blocks can serve as useful alternatives in cases where epidural analgesia is not feasible. This study was conducted to compare the postoperative analgesic efficacy of continuous suprainguinal fascia iliaca (SFICB), infrainguinal fascia iliaca(IFICB)and femoral nerve blocks(FNB) in patients being operated for proximal femur fractures.

Methods After written informed consent, this prospective, randomized, double-blind study was conducted in 60 patients scheduled to undergo proximal femur fracture fixation under general anesthesia. Patients were randomized to one of three groups of 20 patients each to receive either continuous FNB (Group F), IFICB(Group I) or SFICB(Group S).Prior to extubation, USG-guided continuous FNB, IFICB or SFICB was administered using 0.3ml/kg of 0.2% ropivacaine as a bolus followed by a continuous infusion of 10mL/h of 0.2% ropivacaine for 24hours via a catheter. All patients were assessed for severity of pain at 0, 2, 4, 8, 12 and 24hours. Patients with a VAS>4, were given intravenous morphine(0.05mg/kg). We recorded time to administration of first rescue analgesic and 24-hour morphine consumption.

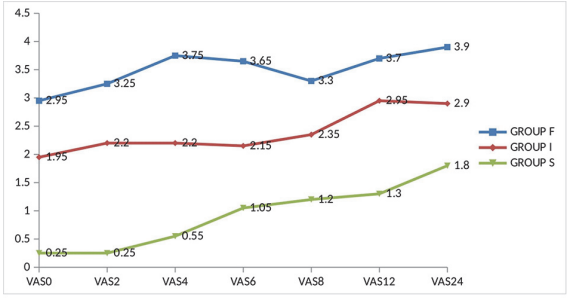


Figure 1: Mean VAS score at different points of time (0,2,4,6,8,12 and 24 hrs) under three different groups F (FNB), S (SFICB) and I (IFICB)

Abstract OP053 Figure 1 Mean VAS score at different points of time (0,2,4,6,8,12 and 24 hrs) under three different groups F (FNB), S (SFICB) and I (IFICB)