



**Abstract #35053 Figure 2** This animation depicts the relative anatomy for the EOI fascial plane block. Note that the origin of the external oblique muscle is at the external surface of ribs 5 through 12. The tip of the Tuohy needle can be seen at the fascial layer between the external oblique muscle and intercostal muscles. This is the plane where local anesthetic is placed to anesthetize the lateral and anterior cutaneous branches of the intercostal nerves. Illustrator: Kishan Patel, MD

**Conclusions** 30ml of 0.25% bupivacaine mixed with 20ml of liposomal bupivacaine was used and 12.5ml of this mixture was injected at each level. The average OME for each postoperative day was higher in the control group compared to the EOI group. The average OME values in the control group were close to double on POD 0 and 1 and more than doubled on POD 2 and 3 compared to EOI group. The EOI block made a clinically significant difference in our patients' opioid usage and overall satisfaction. The EOI block is superficial with reliable sonoanatomy and can be performed in the supine position without interfering with the surgical incision. Most importantly it can be performed in liver transplant patients with ongoing coagulopathy.

**Attachment** EOI\_livertransplant\_ESRA\_abstract\_final.docx

#### #34509 GENERAL ANESTHESIA AND CAUDAL BLOCK FOR LIPOSUCTION AND ABDOMINOPLASTY

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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** Using the regional anesthesia with GA in some surgeries has many benefits including but not limited to reducing the use of intra-operative and postoperative narcotics

**Methods** 53 years old female patient presented to our anesthesia clinic for abdominoplasty and Liposuctions of the back and the abdomen. She has no comorbidity and the Caudal anesthesia with GA was discussed with her and she agreed and consent was signed. Blood investigations were done including coagulation profile. First we started with GA with propofol and Remifentanil after turning the patient prone, Caudal anesthesia was given. postoperative protocol for analgesics was as follows: Paracetamol 1 gm intravenous every 8 hours if pain score is 4 or less and 50 mg Pethidine intramuscular if pain score is 5 or more

**Results** Operation was done successfully and patient shifted to PACU pain -free with No post-operative side effect of narcotics. Her first request of narcotics was after 18 hours and only Paracetamol Every 8 hours.

**Conclusions** Caudal Block prolonged the analgesia postoperative with minimal or no side effects from narcotics

#### #35786 REBOUND PAIN AFTER REGIONAL ANAESTHESIA

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

**Background and Aims** Rebound pain after regional anaesthesia (RA) is often an under-recognised yet debilitating condition occurring after resolution of the nerve block. Rebound pain disrupts functional recovery, postoperative discharge and patient satisfaction. This retrospective audit aimed to investigate the incidence and factors associated with rebound pain in patients undergoing surgery.

**Methods** Data was retrospectively collected from patients who underwent surgery in Khoo Teck Puat Hospital, Singapore, over a period of 1 year, and had received single-shot peripheral nerve block or spinal anaesthesia. Patient demographics, surgery types, Visual Analogue Scale scores, upon resolution of RA, were collated.

**Results** A total of 1177 patients were studied. Incidence of severe rebound pain was low, 0.8% at rest and 4.5% on movement. Incidence of moderate rebound pain was 6.4% at rest and 19.1% on movement. Age  $\leq$  55, Indian ethnicity, surgical type and surgical site were associated with increased rebound pain at rest ( $p < 0.05$ ). Female gender, Indian ethnicity and surgical site were associated with increased rebound pain on movement ( $p < 0.05$ ). Moderate-severe rebound pain at rest and movement were common in tibia surgeries (66%) , shoulder surgeries (53 – 73%) and below- knee amputations (20 – 60%).

**Conclusions** Younger patients ( $<$  55 years old), Indian race, and operations such as shoulder, tibia and below-knee amputations have higher rebound pain scores. Understanding the risk factors can help to identify patients who will benefit from