

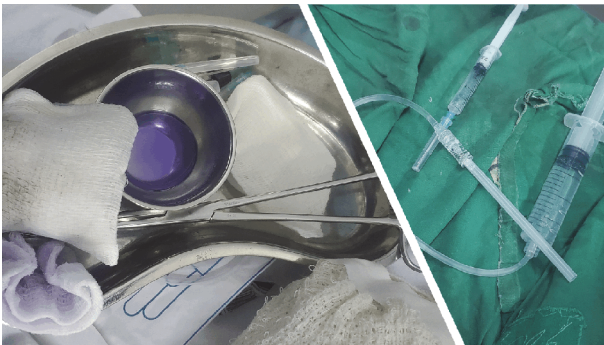
Background and Aims I recently spent six months working at Bugando Medical Centre, a tertiary referral hospital in Mwanza, Tanzania. During my time there, I had the opportunity to perform and teach ultrasound-guided regional anaesthesia to other anaesthesia providers.

Methods Despite the well-known benefits, regional anaesthesia was not widely used due to various challenges including: * Lack of expertise: very few trained regional anaesthesia providers. * Lack of equipment: Safe regional anaesthesia requires ultrasound machines, regional block needles and drugs, which was often unavailable in Tanzania. * Lack of resources: Regional anaesthesia can be expensive, and LMICs often have limited funding for 'non-essential' services * Lack of trust: Surgeons and patients were not too familiar with regional techniques and were reluctant to utilise it. (Gupta, A.; 2016)

Results Despite these barriers, regional anaesthesia became a valuable tool for providing safe and effective anaesthesia at Bugando. Some ways to overcome these barriers and advance regional anaesthesia including: * Training more regional anaesthesia providers. * Providing access to equipment such as ultrasound machines and needles. * Increasing funding for regional anaesthesia. * Educating surgeons and patients about the benefits of regional anaesthesia. (Mukherjee, S., 2017)



Abstract #36317 Figure 1 Ultrasound scanning practice session on real persons



Abstract #36317 Figure 2 Equipment used for regional anaesthesia (spinal sterile set and 22G spinal needles)

Conclusions Regional anaesthesia in Tanzania was challenging due to a lack of resources, infrastructure and trained personnel. However, with a short training program, it became an essential tool for providing safe and effective anaesthesia. By turning challenges to opportunities, we increased the use of

regional anaesthesia, thereby improving the safety and quality of anaesthesia care provided. (O'Connor, B., 2018)

#36039 MULTIPLE BLOCK ANALGESIA FOR COMPLICATED SHOULDER SURGERY

Prashanth Prabhu*, Vasudev Preetham, Poornashree G, Saranya Narayanan. *Anaesthesiology, Vydehi Institute of Medical Sciences and Research Centre, Bangalore, India*

10.1136/rapm-2023-ESRA.621

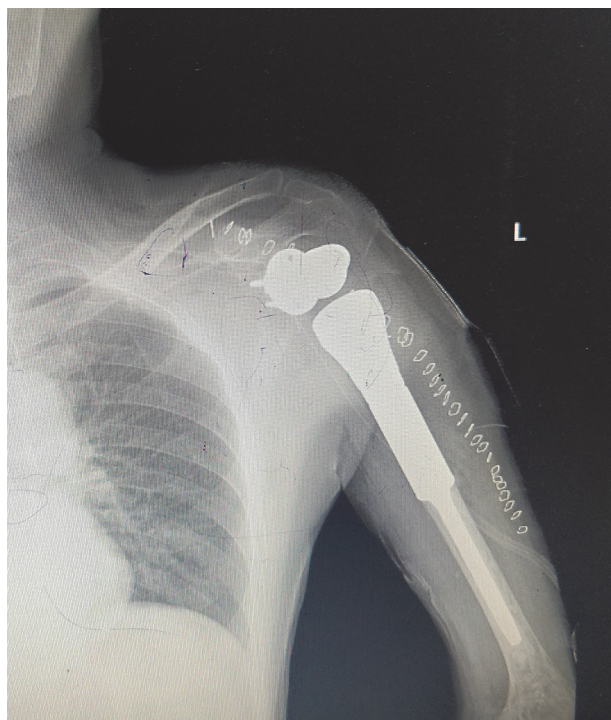
Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

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

Background and Aims A 59yr old male came with complaints of difficulty in left shoulder movement since 8months associated with pain. On MRI, it was diagnosed as diffuse large B cell lymphoma measuring 20X22X82mm with healed pathological fracture of left proximal humerus. He was advised for left proximal humerus excision with shoulder arthroplasty.

Methods On the day of surgery, patient was shifted to OT, monitors connected, IV cannula established. Patient did not want to undergo surgery with regional anaesthesia. Hence surgery was done under general anaesthesia. With this extensive surgery and as patient had previous history of pain, multiple blocks was planned in order to give pain relief postoperatively.

Results 0.25% bupivacaine was used in multiple ultrasound-guided blocks for analgesia and later extubated. -10ml used for selective upper trunk brachial plexus block to target dorsal scapular nerve and lower subscapular nerve. -5ml used for superficial cervical plexus block to target supraclavicular nerve. -15ml used for supraclavicular brachial plexus block to provide analgesia to area supplied by lateral pectoral nerve, suprascapular nerve and axillary nerve. -5ml given as intra-articular infiltration posteriorly as posterior part of shoulder have high concentration of mechanoreceptors. Additive Inj. Dexamethasone 6mg IV given to prolong the analgesia. Post-Operative patient had a VAS score of 1/10 and continued to have pain relief for the next 36hours.



Abstract #36039 Figure 1 Postoperative left shoulder X-ray

Conclusions Multiple blocks was administered for this complicated shoulder surgery to provide adequate analgesia for the patient.

#36495 SERRATUS POSTERIOR SUPERIOR INTERCOSTAL PLANE BLOCK FOR MINIMAL ACCESS BY-PASS SURGERY: A REPORT OF THREE CASES

¹Bora Bilal*, ²Serkan Tulgar, ³Ali Ahiskaloğlu, ⁴Çiftçi Bahadır, ⁵Selçuk Alver. ¹KSU Faculty of Medicine, Kahramanmaraş, Turkey; ²Samsun University, Samsun, Turkey; ³Atatürk University, Erzurum, Turkey; ⁴Medipol University, İstanbul, Turkey

10.1136/rapm-2023-ESRA.622

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 Presently, minimally invasive procedures like minimal access surgery is preferred for elective By-Pass surgery as it provides the cosmetic advantage and avoids sternal complications like infection and postoperative pain. Even with this surgical technique, postoperative pain is often intense and challenging to control. Recently, we have described a novel interfascial plane block technique: Serratus posterior superior intercostal plane block (SPSIB). SPSIB is performed into the fascial plane between serratus posterior superior muscle and the intercostal muscles at the level of second and third rib. Herein, we want to report our successful analgesic experiences of SPSIB in 3 patients underwent minimal access By-Pass surgery.

Methods Written informed consents were obtained from the patients for this report. After the identification of the anatomical landmarks with US guidance the transducer was slightly rotated to obtain an oblique visualization. The needle was inserted just above the third rib deeply to the SPSm. 30 ml of 0.25% bupivacaine administrated between SPSm and rib. We evaluated the pain levels with the Numeric Rating Scale (NRS) for the postoperative 24 hours period.

Conclusions The advantages of SPSIB are; it is safe and simple due to US-guidance. Since the second or third rib is an anatomical landmark, it is a naturel barrier in front of the pleura. Considering that SPSIB is a superficial block, it can be performed more safely in patients receiving anticoagulation therapy. In conclusion, SPSIB may be a good choice for postoperative analgesia management as a part of multimodal analgesia in patients minimally invasive cardiac surgery.

Attachment Table 1.docx

#34299 SUPERIOR TRUNK BLOCK IN ANATOMICALLY VARIANT BRACHIAL PLEXUS

Tam Al-Ani*, Karin Belch. *Anaesthesia, NHS Greater Glasgow and Clyde, Glasgow, UK*

10.1136/rapm-2023-ESRA.623

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 The reported incidence of anatomical variation of the brachial plexus in the interscalene groove varies and is based on different cadaveric studies with unknown clinical effects on the regional block efficacy. This case describes the analgesic efficacy of superior trunk block for shoulder surgery in anatomically variant brachial plexus.

Methods A 58-year-old patient was booked for right shoulder joint replacement. The patient consented to receive general anaesthesia and a brachial plexus block for analgesia. Ultrasound-guided scanning of the interscalene groove at the level of C6 revealed an unusual anatomy with the superior trunk located anterior to the anterior scalene muscle (image 1). The superior trunk was blocked above the anterior scalene muscle with 5ml of 0.25% levobupivacaine injected anterior and 7ml posterior to it (image 1). Similar anatomical variation was also noted on the contralateral side (image 2). Written consent was obtained from the patient to publish this abstract.

Results Block effects are summarised in the table 1 below.

Abstract #34299 Table 1 Block effects summary

Total surgical time	140 minutes
Total morphine consumption intraoperatively	10mg
Pain scores (0-10) in the recovery room (recorded every 10 minutes)	5, 4, 2, 6, 4
Total morphine consumption in the recovery room	15mg
Motor block to shoulder abduction (power assessment: 1-5) in the recovery room	3
Sensory block to cold sensation (Shoulder C5-C6 dermatomes) in the recovery room	Reduced
Total morphine consumption on the ward	105mg