Conclusions This case report shows reduced analgesic efficacy of superior trunk block performed anterior to the anterior scalene muscle in the anatomically variant brachial plexus.

Abstracts

PERICAPSULAR NERVE GROUP BLOCK ADDED TO FEMORAL AND LATERAL FEMORAL CUTANEOUS NERVE BLOCK USED FOR POSITIONING PATIENTS WITH HIP FRACTURES FOR SPINAL ANAESTHESIA

Background and Aims A retrospective evaluation of the analgesic efficacy of two nerve block techniques used in patients with neck of femur fractures before positioning them for spinal anaesthesia. Technique A: pericapsular nerve group (PENG) block, femoral and lateral femoral cutaneous nerve block and technique B: femoral and lateral femoral cutaneous nerve block. Intravenous propofol and alfentanil boluses were used in both techniques as a rescue measure to manage pain during positioning and spinal anaesthesia.

Methods Twenty-nine trauma patients with neck of femur fractures who underwent hemiarthroplasty surgery between Feb 2022- Feb 2023 were included. Retrospective data were collected from anaesthetic charts. Only patients with documented normal cognitive status who underwent spinal anaesthesia on the left lateral position with the fractured side uppermost were included. Both blocks in techniques A and B were performed preoperatively and intended to provide peri and postoperative analgesia. The analgesic efficacy for both techniques was assessed by the number of times rescue intravenous propofol and alfentanil boluses were used to manage pain during positioning and spinal anaesthesia procedure. The z-test statistical test was used to analyse the results.

Results Patients who received Technique A required fewer intravenous propofol and alfentanil boluses during positioning. No intravenous boluses were needed during the spinal anaesthesia procedure, providing better analgesia quality than Technique B with a p-value of $1.13 \times 10^{-7}$.

Abstract #34300 Table 1

<table>
<thead>
<tr>
<th>Technique</th>
<th>Rescue intravenous boluses given during positioning (n=29)</th>
<th>Rescue intravenous boluses given during spinal anaesthesia procedure (n=29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>25</td>
<td>4</td>
</tr>
</tbody>
</table>

Conclusions Adding a PENG block to femoral and lateral femoral cutaneous nerve blocks provided better analgesia for positioning and spinal anaesthesia than femoral and lateral cutaneous nerve blocks alone.

PARASTERNAL PLANE BLOCK FOR THE AWAKE STERNAL SURGERY

Background and Aims The analgesic efficacy of parasternal plane block in pain management after cardiac surgery and sternal fractures has been reported in multiple studies. However, evidence of its use as a sole anaesthetic technique for awake sternal surgery is scarce. This case report describes using this block technique in awake surgery involving the sternum.

Methods A 66-year-old patient with poorly controlled diabetes and unstable angina due to severe and inoperable multivessel coronary artery disease was booked for debridement and washout of an infected deep sternal wound involving the periosteum. The patient consented to have the procedure awake under a parasternal plane block. An ultrasound-guided bilateral parasternal plane block alongside the lateral edges of the sternal wound was performed using safe doses of local anaesthetic

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 Anaesthetiologist (Aged 35 years old or less)
(a total of 40 ml of 3.75mg/ml levobupivacaine) injected in the
plane between the medial edge of the pectoralis major
muscle anteriorly and the intercostal muscles and ribs posterior-
ly targeting the anterior cutaneous branches of the intercostal
nerves. Written consent was obtained from the patient to
publish this abstract.

Results The anaesthesia and surgery were completed unevent-
fully without any adverse effects on the patient's haemodynamics.

Abstract #34298 Figure 1 Parasternal Plane Block- Right side

Abstract #34298 Table 1 Block effects

<table>
<thead>
<tr>
<th>Effect</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>The time from block completion to</td>
<td>20 min</td>
</tr>
<tr>
<td>knife to skin</td>
<td></td>
</tr>
<tr>
<td>Total surgical time</td>
<td>58 min</td>
</tr>
<tr>
<td>Median intraoperative pain score</td>
<td>0</td>
</tr>
<tr>
<td>(0-10)</td>
<td></td>
</tr>
<tr>
<td>Median pain score (0-10) until hospital discharge</td>
<td>0</td>
</tr>
<tr>
<td>The time from theatre discharge to</td>
<td>3 hours 19 minutes</td>
</tr>
<tr>
<td>hospital discharge</td>
<td></td>
</tr>
</tbody>
</table>

Conclusions Parasternal plane block effectively provided anaes-
thesia and analgesia for sternum surgery.

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 Adequate pain control after blunt upper
thoracic injuries such as sternal fracture and ribs fracture is
deemed essential to improve patient’s overall outcome as often
these injuries can impaired patient’s breathing, lead to atelecta-
sis and impaired cough which may progress into respiratory
failure. Thoracic epidural has been the gold standard analgesia
for thoracic injury. However, newer techniques like erector
spinae plane (ESP) block has been described which is simple
and safe to perform. We present a case of high ESP block at
T1 in pain management of sternal fracture and first rib frac-
ture with sternoclavicular joint disruption.

Methods 32 years old gentleman sustained right 1st rib and
sternum fracture with mild right hemotorax and lung contu-
sion and dislocation of right sternoclavicular joint with poste-
rior dislocation of medial end of clavicle after a high impact
road traffic accident. Despite high doses of morphine given,
pain scoring by visual analogue scale remain 8 on movement.
Therefore, a single shot right erector spinae plane block at
the level of transverse process T1 was done.

Abstract #34503 Figure 1 Chest X-Ray showing right first rib
fracture and sternoclavicular disruption