and could ambulate at 24 hours with minimal support. (figure 1).

Results The demographic and block characteristics are described in figure 2. Fentanyl supplementation was needed in 3 patients during the procedure. In the recovery area, only 2 patients [2-level TLIF] reported an NRS of 5/10 and required fentanyl bolus. At the end of 24 hrs, all the patients could ambulate with support without any significant pain. No adverse effects were reported apart from mild nausea in one patient.

Abstract #36010 Figure 1 US image of block. MC-S2 median crest; IC intermed. crest; PSF-parasacral foramen; MF-multifidus; LTM-long thoracic muscle. Post-block ultrasound image: LA-local anesthetic drug

Abstract #36010 Figure 2 Demographic parameters, drug composition, & block characteristics

Conclusions Sacral ESB is an easy, effective and safe technique in the scheme of multimodal analgesia as a component of preemptive analgesia, where the main goal is an opioid-sparing effect and a decrease in opioid-related side effects for TLIF surgeries.

Conclusions SMT–BPB is a refined technique of interscalene block under ultrasound guidance that precisely targets only the Superior and Middle Trunk, with a lower volume and slower injection that prevents phrenic nerve palsy. Thus, RA can be used to the advantage of high–risk patients, in whom conventional interscalene is avoided for the risk of phrenic nerve palsy.

Attachment Ethical Committee SMTBPB.pdf
for shoulder, clavicle and humerus surgeries. Its complications are related to the nervous and vascular structures, such as nerve injury, Horner’s syndrome and phrenic nerve block. Ipsilateral recurrent laryngeal nerve block (RLNB) is a rare complication related to ISB, typically manifested by hoarseness.

Methods A 34-year-old male, ASA II, was scheduled for intramedullary nailing of the humerus, due to humeral shaft fracture. General anesthesia was induced and the airway secured with tracheal intubation, after which a single-shot ultrasound-guided ISB was performed, resulting in the administration of 13 mL of 0.5% ropivacaine (65 mg).

Results Hemodynamic and respiratory stability were maintained throughout the intraoperative period. Following the surgery, neuromuscular block was reversed and the patient had an uneventful emergence. The patient was clinically stable, but exhibited hoarseness. He was then transferred to the Post-Anesthesia Care Unit, where ultrasound was used to assess vocal cord mobility and diaphragmatic function, revealing paresis of both the ipsilateral vocal cord and hemidiaphragm. RLNB and phrenic nerve block were assumed, having spontaneously reversed after a period of watchful waiting, resulting in complete clinical resolution.

Conclusions Hoarseness after shoulder surgery is a rare but known complication with multiple etiologies, including ISB-related neuropraxia and RLNB. In these cases, patient reassurance is paramount, and a watchful waiting approach should be employed, allowing time for a block to reverse.

**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** Safe & effective perioperative analgesia is required for early recovery after open pyeloplasty surgeries. A single-shot caudal block is a widely accepted choice, however, it does not provide prolonged analgesia, and the addition of an adjuvant come with its inherent adverse effects. US-guided costo transverse block (CTB) has recently been introduced with cadaveric studies and clinical case reports, showing promising perioperative analgesia.

**Methods** After parental written informed consent, US-guided costo transverse block (CTB) was performed after general anesthesia (prone position) in 10 ASA I patients (mean age 3.95 yrs, weight 14.4 kg), scheduled for pyeloplasty surgery and 2 mg/kg of 0.2% ropivacaine was deposited at three levels (thoracic T9-10,11,12). (figure1) Intraoperatively all patients received IV paracetamol and continued 6th hourly. Any pain response was not relieved by consolation and IV paracetamol was managed with fentanyl rescue (0.5 mcg/kg).

**Results** The mean duration of surgery was 137 minutes. Intraoperatively 4 patients required fentanyl rescue. The mean time to rescue analgesic (fentanyl) not controlled by consolation and IV Paracetamol was 3 hrs, however, it was observed only in two patients. (table 1) None of the patients had any incision response. All the patients recovered well with a median FLACC on awakening 1/10 (0-2). All the patients had a good sleep with a median FLACC at 24 hours of 0/10 (0-1) and a maximum FLACC score of 4 in only one patient. (figure 2) We did not observe any procedure or local anesthetic-related complications.

Conclusions US-guided CTB with multimodal analgesic provides safe and effective perioperative analgesia in pediatric open pyeloplasty surgeries.