Background and Aims The axillary region has always been a challenge for anesthesiologists. Brachial plexus, paravertebral and intercostal blocks achieve only partial anesthetic coverage. Pecto-serratus plane block technique showed to be effective as an analgesic technique for axillary node dissection during breast surgery. We modified the method in order to enhance local anesthetic spread to the axillary region and achieve surgical anesthesia even for more destructive surgical procedures.

Methods For the modified-pecto-serratus-plane block (m-PSP) we use a 100 mm short beveled echogenic needle (Stimuplex Ultra 360 – Bbraun – Melsungen – Germany) and perform the injection in the fascial plane between the pectoralis minor and serratus muscle in a medial to lateral direction above the third rib instead of the fourth as described by Blanco in his original PECS 2 block.

Results We applied the m-PSP in several surgeries involving the axillary region as a single block or in combination with other techniques to achieve surgical anesthesia. For example, we managed a case of a true axillary aneurysm (consent obtained) requiring an ipsilateral cephalic vein-graft, with the combination of m-PSP and infra-clavicular brachial plexus block (ICB). The m-PSP covered skin (T2-T4 lateral-cutaneous branches; intercostobrachial nerve; medial-cutaneous nerve of the arm) and soft tissues of the axilla for the surgical access; the ICB with the double-bubble sign (direct perivascular local anesthesia; complete coverage of arm and forearm) allowed the axillary artery surgical manipulations and the vein-graft harvesting.

Conclusions For axillary surgeries, adequate knowledge of anatomy allows regional techniques to be adapted and combined covering all surgical maneuvers.

Abstract #36205 Figure 3  Surgery: under mild sedation and collaborating patient, resection of the axillary aneurysm (AAA) and harvesting of ipsilateral cephalic vein in the forearm (VGHS: Vein-Graft Harvest Site)

Conclusions For axillary surgeries, adequate knowledge of anatomy allows regional techniques to be adapted and combined covering all surgical maneuvers.

Abstract #36205 Figure 2  Infra-Clavicular Brachial plexus block: needle below the axillary artery; local anesthetic spread forming the double-bubble sign and involving the tunica adventitia of the artery and the cords of the brachial plexus

Abstract #36205 Figure 1  Modified-Pecto-Serratus-Plane block: needle over the 3rd rib, medico-lateral spread of local anesthetic (LA) along the plane between pec minor and serrates anterior muscles, toward the axillary region

Background and Aims Elderly frail patients with multi-organ failure present a challenge to anesthesiologists during emergency procedures.

Methods 85 years old female patient with acute left upper limb ischemia was posted for emergency exploration with fasciotomy. Her left arm has acute Ischemia following arterial cannulation of the left brachial artery in the intensive care unit. She is a known patient with oesophageal adenocarcinoma, and has a respiratory failure, aspiration pneumonia and lung collapse with bilateral pleural effusion on MV with tracheostomy. She also has IHD, atrial fibrillation on amiodarone infusion and Urosepsis with septic shock on noradrenaline. Her GCS is 9/15. In addition, she also has a history of DM, hypertension and CKD. Blood investigations were done, including CBC, ABG, electrolytes and Renal functions. The case was discussed and the plan implemented with supra-clavicular brachial plexus block with sedation. The patient went into surgery after discussion and consent of the family. The standard monitors and the mechanical ventilator were attached to the patient in the supine position and Inotropic support

Regional Anesthesia for Emergency Surgery for Critically Ill Elderly Patient. Case Report

Regional Anesthesia for Emergency Surgery for Critically Ill Elderly Patient. Case Report

Ahmed Badawy*, Ahmed AE Motalib. Anaesthesia, Danat Al Emarat Hospital, Abu Dhabi, United Arab Emirates; Anaesthesia, NMC Royal Hospital, Abu Dhabi, United Arab Emirates

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and amiodarone were continued. The block was done under Ultrasound guided with complete sterile precautions.

Results The surgery was done successfully, and the patient was transferred back to the ICU.

Conclusions US guided nerve block became the cornerstone in many critical surgeries which has made them easier with high stability of vital signs.

Attachment REGIONAL ANESTHESIA FOR EMERGENCY SURGERY FOR CRITICALLY ILL ELDERLY PATIENT (1). pdf

Abstract #33947

A. El Motalib Ahmed

Results

Abstract #36083

IS OCCLUSIVE WOUND DRESSING AN ADEQUATE INFECTIOUS BARRIER FOR ULTRASOUND-GUIDED INTERVENTIONAL PROCEDURES?

Admir Hadzic*, Angela Lucia Balocco, Frédéric Polus, Robbert Buck, Jonas Bruggen, Isabelle Lenders, Imré Van Herreweghe, Sam Van Boxtael. Anesthesiology, Ziekenhuis Oost-Limburg, Genk, Belgium

10.1136/rapm-2023-ESRA.638

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 Ultrasound-guided interventional analgesia and vascular access procedures (UGNB&VA) are common in clinical practice. During UGNB&VA, the skin integrity is breached by the needle, which can lead to transducer and cable contamination with blood and pathogens. Surprisingly, no universally accepted infectious precautions exist, and the infectious precautions reportedly vary among different countries and practices. We conducted a poll of anesthesiology practitioners to gauge their opinion of whether occlusive wound dressing constitutes an adequate infectious barrier when performing UGNB&VA.

Methods The subscribers to the NYSORA community channel (n=130,000) were polled to assess their perception of whether using a wound dressing (e.g., TEGADERM®) covering the ultrasound probe, but not the cable, constitutes an adequate infectious precaution measure.

Results

Of the 130,000 community members (82% anesthesiology professionals), 0.6% posted a vote (n= 721), figure 1.