Fifty percent of respondents opined that wound dressing constitutes adequate infectious precaution measure during UGNB&VA, although the cable and exposed parts of the transducer are often contaminated with blood during UGNB&VA. The other 50% of the community felt that it was not adequate (26%), or they were not sure (24%).

**Conclusions** Our poll suggests that there is no consensus on infectious precaution measures during UGNB&VA. International guidelines vary on their recommendations on whether both the transducer and its cable should be steriley covered when performing UGNB&VA. Given the rapidly increasing number of UGNB&VA procedures, we advocate for a collective effort to create universal infectious recommendations.

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**#34484**

**CONTINUOUS SUPRAINGUINAL ILIAC FASCIA BLOCK AS ANALGESIC STRATEGY FOR TOTAL HIP ARTHROPLASTY**

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**Background and Aims** Regional anesthesia contributes to a multimodal analgesic approach. Suprainguinal Iliac fascia block is an alternative or complementary analgesic technique for knee, thigh and hip surgery.

**Methods** 80yo female, ASA II, with history of DM2 and hypertension proposed for total hip arthroplasty. To perform the block and catheter placement, a suprainguinal ecoguided approach was used. With the patient supine, a linear high frequency probe was placed in the sagittal plane to obtain an image of the ASIS. The probe was moved medially and the fascia iliaca identified. An in-plane approach and a Stimu-Cath® Continuous Nerve Block Set with a 17G Touhy needle and a 19G multi perforated catheter were used. 20mL 0.2% ropivacaine was given to open the fascial plane and the catheter introduced 3 cm in a cephalad direction. The surgery was realized under spinal anestesia. After the procedure a ionic contrast agent was infused through the catheter and X-ray images were obtained confirming the correct placement and spread. A bolus of 30ml ropivacaine 0.2% 6/6h through the catheter was prescribed and the analgesic regimen completed with NSAID and paracetamol. The catheter was removed 48h later.

**Results** The surgery lasted 70' and there were no complications nor allergic reactions to the contrast. The patient remained comfortable with no pain at rest and minimal pain at movement during the hospital stay and no rescue analgesia was necessary.
Low-cost phantom for ultrasound guided nerve block and vascular catheterization techniques

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Background and Aims Simulation is an important learning tool with growing interest in anesthesiology practice. To our knowledge, there is no low-cost medical model to simultaneously simulate peripheral nerve blocks and catheterization of central vascular accesses guided by ultrasound. Our goal was the creation of a low cost and high reliability medical model for this purpose.

Methods We present a model for training of ultrasound guided vascular catheterization and nerve block techniques. We have developed a simple low-cost anatomical phantom from pork meat. A yellow long tubular balloon with spaghetti inside simulates the nerve, a red long tubular balloon with a paper straw and red dye inside simulates an artery and a long blue tubular balloon with blue dye inside simulates a vein. We describe all the materials needed, as well as the preparation method.

Results Using an ultrasound, we recognize the three types of vasculo-nervous structures, the nerve as a hyperechoic non-compressible structure with a honeycomb appearance, the artery as a hypoechoic non-compressible structure and the vein as a hypoechoic compressible structure. The phantom we created, made of meat, seems to be an extremely realistic simulation of the human tissues, as well as a safe and cost-effective method of learning. It is easy to create, with materials that are easily accessible and low-cost.

Continuous suprainguinal iliac fascia block may be another option in the pain management in non fast-track total hip arthroplasty

Abstract #35935 Figure 1  Low-cost phantom

Conclusions Simulation is becoming a routine part of anesthesiology education and training. Regional anesthesia and vascular catheterization are easy reproducible techniques. Our model is simple, inexpensive, and realistic and we believe it is a very useful training tool for any anesthesiology department.

Continuous erector spinae plane (ESP) block for awake palliative mastectomy in a patient considered unfit for general anaesthesia

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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)

Application for ESRA Abstract Prizes: I don’t wish to apply for the ESRA Prizes

Background and Aims 85 year female, ASA Class 4, with multiple comorbidities was planned for palliative right mastectomy. She had severe pulmonary hypertension on home oxygen, cardiac resynchronisation therapy, PPM/AICD for sustained VT, Atrial fibrillation, mechanical mitral valve on warfarin, chronic kidney disease stage 4 and diabetes on insulin. She was diagnosed with invasive lobular breast carcinoma in 2019, was deemed high risk for general anaesthesia/surgery and commenced on hormonal therapy. Cancer had now progressed to involve the nipple/skin causing discharge and pain affecting her quality of life. She was referred to the anaesthetic clinic to see if this surgery could be offered under a regional anaesthesia (RA) technique alone.