Abstract #35911 Figure 3  Ultrasound scan of the interscalene groove in neutral position of the neck

Results The surgery was completed solely under the nerve block without requiring any additional analgesic or rescue anaesthesia. The patient remained pain free in the postoperative period and was discharged the next day.

Conclusions Ultrasound guided regional anaesthesia proves to be a boon in high risk upper limb trauma cases. It circumvents the need of airway manipulation in anticipated difficult airway cases and also eliminates the cardiopulmonary effects of general anaesthesia in medically compromised patients.

Abstract #34453 Figure 1  XRAY chest of one of the patients

Conclusions Anterior SSB and CCB can be considered as sole anaesthetic for shoulder surgeries in patients with underlying pulmonary pathology and compromised respiratory function.

Abstract #34453

SELECTIVE ANTERIOR SUPRASCAPULAR BLOCK AND COSTOClavicular BLOCK AS SOLE ANAESTHETIC FOR OPEN SHOULDER SURGERY

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10.1136/rapm-2023-ESRA.651

Background and Aims Interscalene brachial plexus block (ISB) has been used for analgesia and surgical anaesthesia for surgeries on the shoulder. Phrenic nerve involvement following an ISB causes hemi diaphragmatic paralysis (HDP). A combination of anterior suprascapular nerve block (SSB) and costoclavicular nerve block (CCB) have been used for postoperative analgesia. Their ability to achieve surgical anaesthesia without phrenic nerve involvement needs further evaluation. We report two cases of open fixation of proximal fracture of the humerus done under a combination of an anterior SSB and CCB as sole anaesthetic without any evidence of phrenic nerve involvement.

Methods 75 years old male, chronic smoker with COPD, bronchial asthma, old pulmonary tuberculosis, lung fibrosis and chronic atrial fibrillation and pulmonary hypertension of 40 mmHg. 55 years old male with Multiple Myeloma and COPD on BIPAP support. Both patients had poor effort tolerance and low room air saturation. Both patients received dual modality ie. Ultrasonography and Nerve stimulator guided combined anterior SSB and CCB. 10ml 2% Inj.Xylocard and 20ml 0.375% Inj.Ropivacaine were given. USG of the diaphragm done in both patients postoperatively showed no change in the diaphragmatic excursion when compared to the opposite side diaphragm. Shortcoming of this report is that the diaphragm excursions were not assessed before the blocks were done.

Abstract #35102

LOWER LIMP MOTOR WEAKNESS AND SENSORY LOSS FOLLOWING POSTERIOR QUADRATUS LUMBORUM BLOCK AFTER KIDNEY TRANSPLANTATION: A CASE REPORT

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Background and Aims Interscalene brachial plexus block (ISB) has been used for analgesia and surgical anaesthesia for surgeries on the shoulder. Phrenic nerve involvement following an ISB causes hemi diaphragmatic paralysis (HDP). A combination of anterior suprascapular nerve block (SSB) and costoclavicular nerve block (CCB) have been used for postoperative analgesia. Their ability to achieve surgical anaesthesia without phrenic nerve involvement needs further evaluation. We report two cases of open fixation of proximal fracture of the humerus done under a combination of an anterior SSB and CCB as sole anaesthetic without any evidence of phrenic nerve involvement.
undergoing abdominal wall surgeries. We present a case of motor and sensory loss following QLB2.

**Methods**

A 24-year-old male, ASA IV, HT:185cm, BW:70Kg with unremarkable medical history underwent kidney transplantation due to autoimmune renal failure. Application of basic monitoring, induction and maintenance were performed according to standard practice. The patient being placed in lateral decubitus position, QLB2 was performed under ultrasound control prior to emergence with a high frequency linear probe (6-12Hz) placed in transverse orientation at the midaxillary line (MindrayTM TE9 Ultrasound System, China). Using an in-plane technique, the needle (Stimuplex® Ultra 22G-90mm, B. Braun,) was inserted toward the posterior aspect of the QL muscle. After aspiration, negative for blood, 20mL levobupivacaine 0.375%, 0.4 mL/Kg was administered. Emergence and extubation were uneventful.

**Results**

The patient was evaluated using a Visual Analogue Scale (VAS) on the 1st, 4th, 8th, 12th and 24th postoperative hour. Pain was described mild in all assessments. Hip paresis was noticed on the 8th-h. On examination, absence of cold and light touch sensation extending from the upper abdomen to the knee (T7-L2) was recorded. Hip flexion and knee extension were deemed weak (power 4/5). Full mobilization was achieved by the 12th-h. Normal motor function was achieved by the 24th-h while sensory was resumed on the 36th-h.

**Conclusions**

Possible local anesthetic spreading to the lumbar plexus affecting the femoral nerve and consequently psoas, iliacus and quadriceps muscles may has resulted in motor block. Pain was minimal without needing additional analgesia.

**Attachment**

patient consent.pdf

#36455 **THE REGIONAL ANESTHESIA IS AN EFFECTIVE OPTION IN CASES WITH OSTEOGENESIS IMPERFECTA**

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10.1136/rapm-2023-ESRA.653

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**

Osteogenesis Imperfecta (OI) is a genetically inherited disorder characterized by defects in the production of type 1 collagen, resulting in the susceptibility to spontaneous or minor trauma-related bone fractures. Patients with this condition pose major challenges in general anesthesia. We aimed to present our management of regional anesthesia in a patient with OI scheduled for surgery due to osteophytes formation in the elbow joint.

**Methods**

A 41-year-old woman (30 kg, 110 cm) with known history of asthma, was scheduled for surgery an osteophyte in the elbow (figure 1). Due to severe restrictive lung disease, the patient carried high pulmonary risk for general anesthesia. Ultrasound and nerve stimulation guided infraclavicular brachial plexus block (IBPB) was performed using 15 mL and 5 mL of 0.375% bupivacaine for the posterior and lateral cords, respectively (figure 2). A subcutaneous injection of 5 mL of 0.2% bupivacaine was administered at the site of the tourniquet. The surgery was performed while the patient was in a wheelchair due to patient’s limitations (figure 3). Intraoperatively, the patient received 300 mg of intravenous paracetamol.

**Results**

Adequate anesthesia and postoperative 12-hour analgesia were achieved during the 25-minute surgery.