

Results 55 patients (table 1) were enrolled and divided into Hypo-group (hypotension after SA) and NO Hypo-group (no hypotension). The average collapsibility of ICV as well as IV was significantly higher in the Hypo-group (image2). Analysis showed a systolic pattern of hypotension (Image3). The ROC showed high predictive value for ICV (AUC:0.974) as well as IV (AUC:0.985) collapsibility.

Conclusions Our intent was to compare the predictive value of IV versus ICV collapsibility in assessing the risk of hypotension following SA in elderly patients with HF. PoCUS approach allows anesthesiologists to measure preoperative IV collapsibility easier than ICV, providing them the possibility to predict hypotension risk after SA, even in the operating theater.

ePoster session 1 – Station 1

EP001 FREQUENCY OF EPIDURAL CATHETER-INCISION CONGRUENCY AND EFFECTIVENESS OF POSTOPERATIVE ANALGESIA FOR ADULT PATIENTS AFTER MAJOR ABDOMINAL SURGERY: AN OBSERVATIONAL STUDY IN LMIC

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Background and Aims Thoracic epidural analgesia improves pain relief, bowel function, patient satisfaction and accelerates recovery in patients undergoing abdominal surgeries. Effective postoperative epidural analgesia depends on inserting the catheter correctly in the epidural space. The primary aim of this study was to observe the frequency of appropriate epidural catheter insertion site in adult patients scheduled for major abdominal surgeries and secondary objectives were to observe the frequency of ineffective postoperative analgesia, side effects, and complications.

Methods This study was conducted for a period of three months (1st July to 30th September 2022), after the approval from the Ethical Review Committee. All adult patients who underwent elective major abdominal surgery under general anaesthesia with an epidural catheter placed for postoperative pain management were included in this study. Data were collected at Aga Khan University Hospital Karachi.

Results One hundred and eighty-two patients were included in this study. Ninety-six (52.75%) of patients were male. The epidural catheter was inserted congruent to the surgical incision that is at T10/T11 interspace or above in only forty-three (23.6%) patients, below T11 but till L1 in seventy-three (40.15%) of patients, and below L1 in sixty-six (36.3%) patients. In the postoperative period, overall effective epidural analgesia was observed in seventy-nine (43.4%) of patients. Regarding the side effects of epidural infusion, the motor block was observed in sixty-six (36.26%) of patients in the immediate postoperative period.

Conclusions The frequency of appropriate epidural catheter insertion was found in 23.6% of patients. The frequency of ineffective postoperative analgesia was found in 56.6% of patients.

EP002 COMPARATIVE STUDY BETWEEN ULTRASOUND GUIDED SERRATUS ANTERIOR AND ERECTOR SPINAE BLOCK FOR PERIOPERATIVE ANALGESIA IN CHILDREN UNDERGOING UPPER THORACIC SURGERIES

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Background and Aims Perioperative thoracotomy pain management with reduced opioid consumption is beneficial for early recovery. Both erector spinae and serratus anterior plane block have been used in thoracic surgeries. We aimed to compare the USG erector spinae and serratus anterior plane blocks on cumulative opioid consumption and recovery.

Methods After ethical committee clearance, a prospective, randomised study was conducted in patients aged 5 to 14 years undergoing open thoracotomy under general anaesthesia. Seventy patients were allocated randomly into two equal groups of 35 each: Group 1 received Serratus anterior plane block while Group 2 received Erector spinae block respectively. Each group received 0.5 ml/kg of 0.25% bupivacaine with 2 micrograms/ml of fentanyl. The primary outcome of our study was to compare the cumulative opioid consumption between the two groups. The study's secondary outcome was to determine the time of chest physiotherapy initiation, postoperative hospital stay, postoperative pain scores and complications between the two groups.

Results Mean opioid requirement during intraoperative, postoperative period and cumulative was more in Group 1 than in Group 2 with p values of 0.0002, 0.0032 and 0.0024 respectively. The mean time to start chest physiotherapy & mean postoperative hospital stay were higher in Group1 than in Group2 (p-value 0.002 & 0.046 respectively).

Conclusions Ultrasound-guided Erector Spinae block is superior to Serratus anterior plane block in children undergoing thoracic surgery with decreased perioperative opioid analgesia, early chest physiotherapy initiation, and lesser hospital stay.

EP003 TIME TO SURGICAL TREATMENT FOR HIP FRACTURE CARE

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Background and Aims Hip fracture is a common and serious injury, particularly in older adults, which can lead to significant morbidity, mortality, and decreased quality of life. Surgery is the standard treatment for hip fractures, and its timing is crucial for optimal outcomes. Studying the time from hip fracture to surgery can help identify best practices for timely surgery and improve patient outcomes.

Methods This study was approved by the Institutional Review Board at our hospital review board (IRB#2012-050). From the Premier Healthcare database (Premier Healthcare Solutions, Inc., Charlotte, NC; 2006-2021) we identified patients who had a primary diagnosis of hip fracture and underwent surgical procedures. The primary exposure of interest was time from hip fracture diagnosis to surgery (categorized as 0-1 day, 2 days, and 3 days). Outcomes of interest included any major complications, length of stay, ICU admission (identified by billing code), and total opioid consumption during hospitalization.

Results We identified 65,111 patients who underwent surgical treatment within 3 days of hip fracture onsite, with 29.1% of patients receiving the surgery within 1 day, and 53.8% of patients receiving the surgery within 2 days. Prolonged wait time to have surgery increased the risk of having major complications, mortality, ICU admission, and longer hospitalization (table 1).

Abstract EP003 Table 1 Mixed modeling outcomes comparing different time between surgery and fracture onsite

	2 days vs 0-1 day		3 days vs 2 days		3 days vs 0-1 day	
	Adjusted OR (95% CIs)**	p value	Adjusted OR (95% CIs)**	p value	Adjusted OR (95% CIs)**	p value
Major complications*	1.10 (1.07, 1.12)	<.001	1.28 (1.25, 1.32)	<.001	1.17 (1.14, 1.2)	<.001
Mortality	1.12 (1.06, 1.17)	<.001	1.35 (1.27, 1.44)	<.001	1.21 (1.15, 1.27)	<.001
ICU admission	1.06 (1.04, 1.08)	<.001	1.44 (1.41, 1.48)	<.001	1.36 (1.33, 1.39)	<.001
	% change (95% CIs)**	p value	% change (95% CIs)**	p value	% change (95% CIs)**	p value
LOS	18 (17, 18)	<.001	43 (42, 44)	<.001	22 (21, 22)	<.001

*Major complication includes acute renal failure, delirium, myocardial infarction, pulmonary embolism, respiratory failure, stroke, and in-hospital mortality
 ** Mixed-effects models were applied to compare the outcomes between the all three groups in a pair-wise way. Models were adjusted for age, sex, race (black, white, or other), Elixhauser comorbidity index (categorized as 0, 1, 2, 3 or more), admission type (emergency, urgent, elective, trauma center, and unknown), fracture location (femoral neck, subtrochanteric, intertrochanteric, or multiple), type of surgery (total hip arthroplasty, hemiarthroplasty, or internal fixation), type of anesthesia (general, neuraxial, general and neuraxial, PNB, others, and unknown), year of surgery (2006-2021), hospital location (urban versus rural), bed size (<300 beds, 300-500 beds, >500 beds), teaching status, and region (Midwest, Northeast, South, West). A random intercept term that varies at the level of each hospital was included in the model, accounting for the cluster effect of patients within hospitals as they are likely to experience similar care.

Conclusions Delayed surgery after hip fracture is associated with increased morbidity and mortality, increased length of hospital stay, and increased use of resources. It is recommended that healthcare providers prioritize timely surgical intervention for patients with hip fractures to optimize their chances of a successful recovery.

EP004 NEW APPROACH FOR SUPRASCAPULAR NERVE BLOCK: UP TO EASIER

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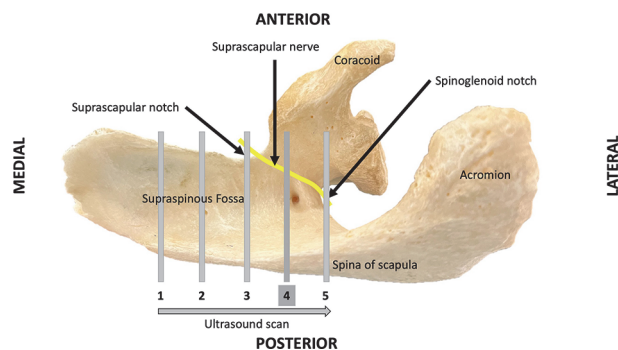
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Background and Aims Suprascapular nerve block (SSNB) is commonly used for shoulder analgesia. Two approaches are described but associated with risk and difficulties. We designed a cadaveric anatomical study to assess availability of an easier posterior approach.

Methods The probe is placed above the scapula, move from medial to lateral to identify the upper edge of the scapula which will be shorter until it reaches the suprascapular notch (1-3). We continue until identify a superior bony growth of the scapula (corresponding to the coracoid process) (4). By

moving laterally, we identify the infraspinous notch(5). Between the image of the suprascapular notch and the spino-glenoid notch, neurovascular bundle runs the fossa (4). At that point, we advance the needle 'out of plane', from medial to lateral, until bone contact. We injected 5ml of contrast, methylene blue and ropivacaine 0.5% mixture. We realize CT scanner and then dissected the suprascapular nerve in order to determine spread injection.

Results In all of the 20 blocks performed, suprascapular fossa was fully covered by contrast. Contrast passed through suprascapular notch (in 80%) and through spino-glenoid notch (in 75%). Anatomical dissections demonstrated that suprascapular fossa was colored in 90%. In 2 case, methylene blue move into suprascapular muscle. Suprascapular nerve is blue-toned in 85% of case before its separation in sensitive and motor branches.



Abstract EP004 Figure 1 US-probe schematical localisation

Conclusions In this pre-clinical study, this SSN approach seems to be effectiveness. We postulate is easier referring to easy identifiable bone structure and associate with less risk.

EP005 PECS 2 BLOCK FOR OPEN BICEPS TENODESIS: NO ANALGESIC BENEFIT VS. SURGICAL FIELD INFILTRATION

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Background and Aims Open subpectoral biceps tenodesis is often performed to treat biceps tendinopathy in conjunction with shoulder arthroscopy. We tested the hypothesis that a Pecs 2 block would provide better analgesia than surgical infiltration following open biceps tenodesis surgery.

Methods Patients were randomly assigned to either the treatment group (Pecs 2 block with 20 mL of 0.25% bupivacaine) or the control group (local infiltration of up to 15 mL of 0.25% bupivacaine by the surgeon). All subjects received an interscalene nerve block using 20 mL of 0.5% bupivacaine, as well as either intravenous sedation or general anesthesia. The primary outcome was opioid utilization during the first 24 hours after surgery (PACU + POD1). Secondary outcomes were NRS pain scores in PACU, on POD1 and POD3, reaction to surgical subpectoral incision (such as motion or