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

[1,2]Pierre Goffin*, [3]Hipolito Landeyra, [4]Alberto Prats-Galino, [5,4]Xavier Sala-Blanch. *[1]Anesthesia and intensive care, MontLegia Hospital, CHC Groupe Santé, Liege, Belgium; [2]Master's Degree in Advanced Medical Competences, Regional Anesthesia Based on Human Anatomy, University of Barcelona, Barcelona, Spain; [3]Human Anatomy and Embryology, University of Barcelona, Barcelona, Spain , University of Barcelona, Barcelona, Spain, Barcelona, Spain; [4]Human Anatomy and Embryology, University of Barcelona, Barcelona, Spain; [5]Depertment of Anesthesia, Hospital Clinic, Barcelona, Spain*

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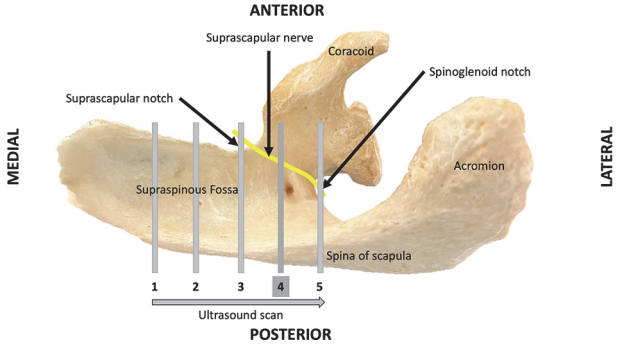
Background and Aims Suprascapular nerve block (SSNB) is commonly used for shoulder analgesia. Two approaches are described but associated with risk and difficulties. We designed a cadaveric anatomical study to assess availability of an easier posterior approach.

Methods The probe is place 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 spinoglenoid 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 spinoglenoid 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

[1]Arthur Hertling*, [1]Germaine Cuff, [2]Thomas Youm, [2]Mandeep Virk, [2]Kirk Campbell, [1]Ekow Commeh, [1]Avra Hammerschlag, [1]Iman Suleiman. *[1]Anesthesiology, NYU School of Medicine, New York, USA; [2]Orthopedic surgery, NYU School of Medicine, New York, USA*

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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