catheter placement, and complications associated with the technique.

Results Our patients were primarily females (59.6%) with a mean age of 48.0 (SD ± 17.7) years and a mean BMI of 27.1 (SD ± 4.5). Most patients (68.6%) were ASA II; the most common blocks were continuous popliteal, interscalene, or infraclavicular blocks. The most common complication reported was accidental catheter removal during follow-up, affecting 7.8% of patients. Only 80 (5.84%) of our patients required re-consultation and 3 of them were re-admitted. No significant complications were found in this cohort.

Abstract EP054 Table 1 Demographic data

Demographic	Patient (n = 1,370)
Age	48(17,7)
BMI	27,05 (4,5)
ASA	
I	368 (29,51%)
II	855 (68,57%)
III	24 (1,93%)
Gender	
Male	554 (40,44%)
Female	816 (59,56%)
Re-consultation	80 (5,84%)

Continuous variables presented as mean (standard deviation); categorical variables presented as frequency (percentage).

Abstract EP054 Table 2 Catheter location

Catheter location	
Interscalene	520 (39,45%)
Infraclavicular	76 (5,76%)
Popliteal sciatic	549(41,65%)
Femoral	17 (1,29%)
Adductor canal	153 (11,61%)
Others	3 (0,23%)

Categorical variables presented as frequency (percentage).

Conclusions In this series of patients, the most common problems described during the follow-up period were minor problems with a low incidence and without significant impact on re-consultation or re-admissions. Overall, continuous regional analgesia at home is a feasible practice that benefits patients and clinicians.

ePoster session 2 – Station 4

EP055 AN AUDIT OF POSTOPERATIVE PRESCRIBING PATTERNS IN A SINGLE CENTRE

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10.1136/rapm-2023-ESRA.117

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Background and Aims Opioids can form an integral role in the post-operative multi-modal discharge prescribing plan, however, in Ireland the prescribing rates of opioids are increasing yearly and inappropriate opioid prescribing from acute hospitals is unfortunately happening. The international guidance for acute post-operative pain specifies simple analgesia with 5 days of opioids (7 days maximum). Sustained release opioids are not recommended [1 2]. Our project aimed to investigate postoperative prescribing patterns in a large teaching hospital in Ireland. Difficulties in accurate data collection under current technological conditions were also explored.

Methods Local ethics approval was acquired prior to initiation of this project. We performed a retrospective chart review, inclusion criteria were patients over 18 years old who underwent elective or emergency surgery between October to December 2022. Exclusion criteria were patients with extended stays (over three weeks) and specialities with written discharge analgesia protocols.

Results 238 charts were included. Median age was 55, range 18-91. 13% of our prescriptions were in line with guidance wherein all patients on opioids should be prescribed simple analgesia. Of these prescriptions only 7.02% had opioids for 5 days or less. 46.2% of patients received a sustained release opioid. Only 23% received NSAIDs. 5 patients received paracetamol in conjunction with a separate paracetamol-codeine combination.

Conclusions This audit has shown a heavy over-reliance on sustained release opioids. It also shows low levels of compliance with national or international guidance on discharge prescribing. Additionally, data collection is hugely complicated using the current system. Digital infrastructure and centralised databases will be necessary in the future.

EP056 IMPROVING THE QUALITY OF LABOUR EPIDURALS

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10.1136/rapm-2023-ESRA.118

Background and Aims Our anaesthetic department provides labour epidural as part of a secondary care maternity service. Recently there has been concern that our rate of accidental dural punctures (ADPs) has increased so we undertook a service evaluation of labour epidurals. We compared our data to the standards set out in 'Raising the Standards: RCoA Quality Improvement Compendium'.

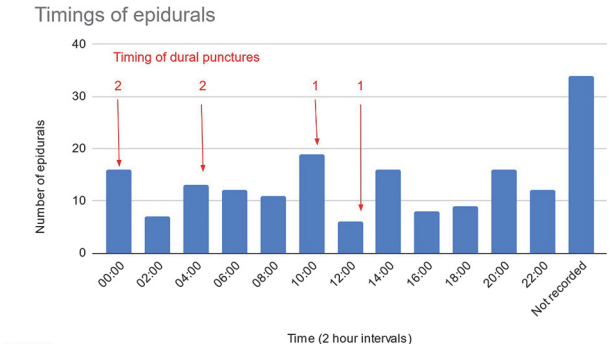
Methods Prospective data collection over a 3 month period. Reviewed the anaesthetic logbook and patient notes to gather: time, grade anaesthetist, epidural technique, incidence of re-siting, incidence of ADP and subsequent management.

Results Standards were met in the following domains block success 93% (target >85%), resites 7% (target <15%), satisfaction at follow-up 98% (target

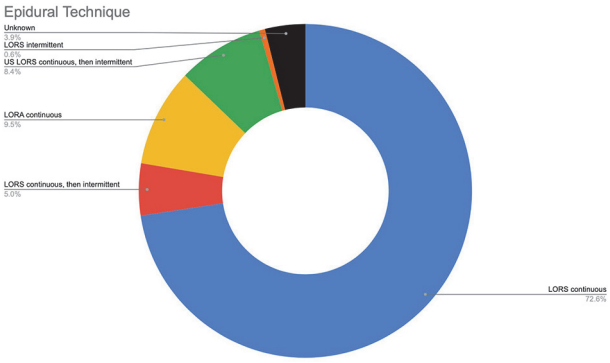
>98%). However, our ADP rate was above range at 3.2% (target < 1%). Despite a range of loss of resistance (LOR) techniques used, this did not impact ADP. Evenings appeared to be the safest time of day, but otherwise even spread over 24 hours. Possibly higher ADP rates from experienced anaesthetists who were returning to the labour ward after a break.

Abstract EP056 Table 1 Management of accidental dural punctures

ADP Case	1	2	3	4	5	6
Epidural Method	LORS continuous	LORA continous	LORS intermittent	LORS continuous -intermittent	LORS continuous	LORS continuous - intermittent
Recognised at the time?	Yes	Yes	Yes	Yes	Yes	No
Managment	Intrathecal Catheter	Resite space above	Resite space above	Resite space below (L3/4)	Resite space above	Procedure abandoned
PDPH	No	No	Yes	Yes	Yes	Yes
Blood patch	No	No	Yes	Yes	Yes	Yes x2 + MRI on advice of neuro (normal)



Abstract EP056 Figure 1 Timings of accidental dural punctures



Abstract EP056 Figure 2 Loss of resistance techniques used

Conclusions Our ADP rate was unacceptable, without a clear explanation. Possibly causes include a change of equipment (we only had combined spinal-epidural sets the year before), a busier labour ward, and turnover of anaesthetic staff newly restarting epidurals. It could be anomalous due to a short data collection window. We gained a model epidural back which is always available for practice and have started collecting data again to see if our unit has improved.

EP057 CADAVER STUDY TO DESCRIBE THE SPREAD OF INJECTATE DURING SIMULATED ERECTOR SPINAE BLOCKS

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10.1136/rapm-2023-ESRA.119

Background and Aims The erector spinae plane (ESP) block is widely used as alternative to more complex neuraxial and para-neuraxial blocks. However, the extent and reproducibility of the injectate spread remain unclear. The aim of this study was to investigate the pattern, extent, and variation in the spread of injectate during simulated ESP blocks.

Methods Bilateral ultrasound-guided ESP blocks were performed at T5 transverse process using iodised-contrast solution in fresh cadavers (20ml x 2). Computed Tomography (CT) imagining was performed 30 minutes after block administration. Two cadavers were dissected after injectate containing dye was administered.

Results The study included 20 sides on 10 cadavers; mean age 58years and mean height 163.6cm. Table 1 shows the frequency of spread across intramuscular planes and neural structures. There was a consistent spread to the dorsal ramus, while spread to neural structures and lateral spread was less predictable (table 2). There was greater spread cephalad than in the caudal direction. An inverse relationship was observed between the extent of LA spread and height. This pattern remained consistent after controlling for confounding variables (table 3).

Abstract EP057 Table 1 Frequency table of Injectate spread from T5 transverse process administration

	Long	Ilio	Spin	Serra	Dors	Icn	Epi	Root	Iclat	Rami
T1	6	2	4	1	0	0	2	0	0	0
T2	17	7	6	4	4	0	2	0	1	0
T3	20	17	12	5	14	2	2	0	0	0
T4	20	18	14	3	17	9	2	3	1	0
T5	20	18	13	3	17	8	3	6	3	4
T6	20	15	12	1	14	2	2	1	1	0
T7	20	4	7	0	7	0	2	0	0	0
T8	17	2	6	0	2	0	2	0	0	0
T9	10	0	3	0	0	0	0	0	0	0
T10	5	0	2	0	0	0	0	0	0	0
T11	3	0	1	0	0	0	0	0	0	0
T12	0	0	0	0	0	0	0	0	0	0

Abstract EP057 Table 2 Cephalocaudal spread of injectate across muscular and neural structures after administration at T5 vertebral level

Table 2: Vertebral spread		
Cephalocaudal spread	Mean ± SD	Range, min-max (IQR)
Mean Posterior Spread		
Cephaled	2.38±0.62	1.33-4(0.67)
Caudad	2.12±0.99	1.33-4.33 (1.08)
Longissimus		
Cephaled	3.15 ± 0.67	2-4 (1)
Caudad	3.75 ± 1.29	2-6 (1.25)
Iliocostalis		
Cephaled	2.2±0.95	0-4 (1)
Caudad	1.05±0.89	0-3 (0.25)
Spinalis		
Cephaled	1.8±1.44	0-4 (1.5)
Caudad	1.55±1.85	0-6 (3)
Mean Anterolat Spread		
Serratus		
Cephaled	0.65±1.18	0-3 (0.5)
Caudad	0.05±0.22	0-1 (0)
Neural structures		
Dors		
Cephaled	1.75±0.97	0-3 (1)
Caudad	1.15±0.93	0-3 (2)
Intercostal nerve		
Cephaled	0.55±0.60	0-2 (1)
Caudad	0.1±0.31	0-1 (0)
Epidural space		
Cephaled	0.4±1.23	0-4 (0)
Caudad	0.3±0.92	0-3 (0)
Root		
Cephaled	0.15±0.37	0-1 (0)
Caudad	0.05±0.22	0-1 (0)
Rami		
Cephaled	0±0	0 (0)
Caudad	0±0	0 (0)
Iclat		
Cephaled	0.1±0.31	0-1 (0)
Caudad	0.05±0.22	0-1 (0)
*number of ribs from T5		