15 ANTERIOR SERRATUS PLANE BLOCK FOR AWAKE BREAST SURGERY; A CASE REPORT

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Background and Aims We report a case of an 87-year-old female patient, ASA 3, with significant comorbidities who underwent awake right breast lumpectomy under anterior serratus plane block (ASPB), because of her high risk for general anaesthesia. Following a right total mastectomy 3 years ago, she presented with cancer recurrence; the lump was located close to the lateral aspect of previous mastectomy scar and close to axilla. The superficial ASPB was chosen because it blocks the nerves that innervate the lateral half of breast and the axilla.¹

Methods Written informed consent was obtained by the patient for publication. The block was performed at the level of the fifth rib at the anterior axillary line with the patient supine. An ultrasound-guided in plane transverse approach was used. A total of 30 ml ropivacaine 0.5% was administered in incremental boluses at the plane between the serratus anterior and the latissimus dorsi (figure 1). The patient was mildly sedated intraoperatively with 75 mcg Fentanyl and 60 mcg Clonidine and tolerated the procedure well.

Results Procedure and recovery were uneventful. She did not complain of any pain and she did not require any painkillers for the next 24 hours following the block. Her pain thereafter was controlled with rescue Paracetamol.

Conclusions Awake breast surgery under ASPB as single block technique is feasible when the surgery is limited to the lateral half of the breast and the axilla. Understanding the anatomy of the surgical technique is important to decide between the various regional techniques available for breast surgery.

Figure 1. Schematic representation of ASPB at the level of the fourth and fifth ribs. SC, Subcutaneous tissue; LD, Latissimus Dorsi; SA, Serratus Anterior; IC, Intercostal muscles; PL, Pectoralis; RA, Fourth rib; RS, Fifth rib; LA, local anaesthetic.

Abstract 15 Figure 1

16 SUCCESSFUL REGIONAL ANESTHESIA MANAGEMENT FOR AWAKE SCAPULAR FRACTURE SURGERY: A CASE REPORT

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Background and Aims Since scapula innervation are very complex, the surgery for scapular fractures usually is done under general anesthesia.¹ The aim was to perform successful regional anesthesia management with mild sedation for awake scapular fracture surgery with selective target block combinations.

Methods A 77-year-old female patient with a right scapula fracture was scheduled for an open reduction and internal fixation by posterior approach at the beach-chair position. With informed consent, we performed the upper trunk block, a selective supraclavicular, and T3 thoracic paravertebral block. Upper trunk block² at the point where it bifurcates into the suprascapular nerve/posterior and anterior division was performed with the in-plane technique and 17 mL of Ropivacaine 0.5% in a semi-sitting position in the supraclavicular fossa. (figure 1A). In this case, the supraclavicular nerve, divided

Abstract 16 Figure 1 A. Ultrasound image of Brachial Plexus, SN; suprascapular nerve, UT; Upper trunk anterior division UTP; Upper trunk posterior division MT; medial trunk LT; Lateral trunk SA; Subclavian Artery B. Ultrasound image of two branches (from C3 and C4) of supraclavicular nerve, SCN; Supraclavicular nerve