maxillary nerve block (second branch of the trigeminal nerve), at pterygopalatine fossa level, promotes effective analgesia to the middle third of the face.

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'THE ANALGESIC PLANE' FOR POSTERIOR CERVICAL SPINE FUSION SURGERIES

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10.1136/rapm-2021-ESRA.20

Background and Aims Posterior C spine fusion surgeries will lead to severe post-operative pain arising from tissue trauma which affects the physiological functions of circulation and respiration as well as seriously affects early activities. We share our experience in this 4 cases which were managed with erector spinae along with GA which was effective during perioperative period.

Methods After informed written consent all 4 patients were anaesthetised by using standard general anaesthesia protocol and positioned prone. High frequency US probe (FUJIFILM SONOSITE M TURBO) placed over the transverse process of C7 (case 1), T1 (case 2), T2 (case 3 & 4) to identify the erector spinae muscles (ESM). Using 23 G quincke needle, by

Abstract 20 Figure 1

Abstract 20 Table 1 Demographic data

	Case 1	Case 2	Case 3	Case 4
Age / sex	67 / M	72 / M	38 / M	51 / M
BMI	22	40	24.2	26
Co Morbidities	NIL	HTN, DM, OSA	Smoker, alcoholic	NIL
ASA physical status	I	III	II	I
Surgical level	C3 – C6	C3 – C6	C5 – C7	C3 – C7
CESP	C7	T1	T2	T2
Surgical duration	240 mins	270 mins	270 mins	300 mins

Abstract 20 Table 2

	Case 1	Case 2	Case 3	Case 4
Additional Intra op opioids use	NIL	NIL	NIL	NIL
Time of post op opioid requirement	12 th & 22 nd hr	16 th & 24 nd hr	14 th hr	14 th & 20 th hr
Total dose of opioid consumption in the post op (mg)	50 + 50	50 + 50	50	50 + 50
Post op complications	NIL	NIL	NIL	NIL

in plane approach the needle tip was placed between ESM and the transverse process. After confirmation with saline, B/L CESP was given (15 ml of 0.25% bupivacaine + 4 mg dexamethasone) on each side. Inj. paracetamol 15 mg/kg was given before skin incision and continued 6th hourly for 1st 24 hrs post op. All patients hemodynamics were monitored. Postoperative pain was assessed using VAS score every hour for the 1st 12 hours and 2nd Hourly till 24 hours. Inj tramadol 50 mg was used for breakthrough pain (VAS score ≥ 4) in the post op.

Results No additional opioids were required during intra op period

Reduced post op opioid requirements

Promotes early mobilization

Conclusions We found CESP provides an excellent site specific intra op and post-op analgesia and reduces the perioperative opioid requirements; thereby promotes early mobilization and hospital discharge.

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CONTINUOUS THORACIC PARAVERTEBRAL BLOCK FOR SIMPLE MASTECTOMY IN A PATIENT WITH MULTIPLE COMORBIDITIES – A CASE REPORT

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10.1136/rapm-2021-ESRA.21

Background and Aims Anesthetic management in patients with multiple comorbidities is challenging for anesthesiologists.

Aim: To highlight the role of continuous thoracic paravertebral block (TPVB) for providing effective anesthesia and analgesia in breast surgery.

Methods A 63 years old female with uncontrolled hypertension, hypothyroid and coronary artery disease (LVEF 26%, NYHA Class III) was scheduled for urgent simple mastectomy for Phylloides tumour of the right breast. Ultrasound guided continuous thoracic paravertebral block was performed at T4 level administering 20 ml of 0.75% ropivacaine bolus followed by 0.2% ropivacaine infusion. Intraoperative sedation was maintained with dexmedetomidine infusion. 0.2% ropivacaine infusion at 5 ml/hr was continued for 48 hrs, after that catheter was removed.

Results Continuous TPVB provided adequate anesthesia, good hemodynamic stability and opioid sparing perioperative analgesia.

The VAS score in postoperative period at rest was 2/10 and on movement was 3/10.

There were no block related complications.

Conclusions Continuous thoracic paravertebral block is quite effective for breast surgery with comparative efficacy but lesser complications than general anesthesia.

Abstract 21 Figure 1

Abstract 21 Figure 2

Abstract 21 Figure 3

22 SACROILIETIS IS A LEADING CAUSE OF FAILED BACK SURGERY SYNDROME: A CASE STUDY

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10.1136/rapm-2021-ESRA.22

Background and Aims Most people experience low back pain at some point in their life with one common cause of back pain. In particular, SI joint pain causes axial back pain affecting between 15 and 25% of people. Pain generated in the SI joint or surrounding structures can present as low back pain, leg pain, sacral pain, pelvic pain, or gluteal pain. Unilateral pain is more common than bilateral. It may be the result of direct trauma, unidirectional pelvic shear, repetitive and torsional forces. Sacroiliac joint pain mostly diagnosed based upon the history and physical examination test.

Currently, most reliable method of diagnosing SIJ pain is a diagnostic block of local anaesthetic directly into the SIJ. Current evidence favours lateral branch radiofrequency (RF) lesioning as the most effective treatment. Moreover, it is an alternative treatment.

Methods Patient developed failed back surgery syndrome for which after discussion with neurosurgeon and patient we have decided to give diagnostic Right SI joint block using inj bupivacaine 0.25% with Triamcilon 40 mg under fluoroscopy with dye guidance. Informed consent taken. Post procedure no neurological deterioration. Patient was kept in hospital for 2 hours and then discharged.

Abstract 22 Figure 1

Results Right SI Joint block under fluoroscopic guidance was performed uneventfully. Post procedure no neurological deterioration. After 2 hours patient got 50% pain relief. All analgesics stopped, Pregabalin was tapered and patient discharged.

Conclusions Interventional pain procedures are minimally invasive day care procedures. In properly selected patients they can prevent surgery, cost effective also decreases Morbidity. If pain is resistant and significant neurological deficit is not there they can prevent unnecessary surgery.