

ceased analgesic medication and remained pain free at 18-month follow-up.

Conclusions Neuropathic pain is a difficult condition to manage due to the biopsychosocial factors involved whereby diverse strategies may have to be utilized. PRF has been shown to be successful in the treatment of a painful neuroma following scar formation and so offers an alternative, medication-free approach to treating this condition.

Miscellaneous

83 ULTRASOUND-GUIDED NERVE BLOCK WITH TELEMEDICINE

S Oku*, Y Mizuno, T Goto. *Yokohama City University, Yokohama, Japan*

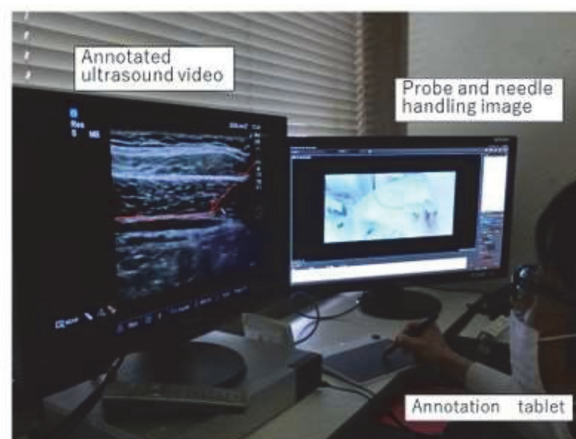
10.1136/rapm-2021-ESRA.83

Background and Aims New skills and knowledges for various ultrasound guided nerve blocks (UGNB) have been developed. Instructions from experienced expert may be essential for the education, however, these chances are limited partly because of availability of the expert instructor.

In this study, we developed telemedicine system for UGNB instruction and investigated whether the system could be useful practically for remote UGNB in 5 patients.

Methods At a practitioner site, video conference device (SONY) with ultrasound machine (Edge, Sonosite) and field camera was set in Sado General Hospital. At an instructor site, the device with annotation tablet and monitors of the ultrasound and the field was set in Yokohama City University Hospital 300 km away (figure 1). Ethics Committee approval and informed consent by the patients were obtained.

Results Two lateral transversus abdominis plane blocks, two rectus sheath blocks and a pectoral nerves II block were performed in 5 patients underwent open inguinal hernia repair, open umbilical hernia repair and mastectomy, respectively. At instructor site, instructor added annotation on ultrasound video, and field camera monitor displayed practitioner's



Abstract 83 Figure 2

handling of the probe and patient position. (figure 2) These simultaneous monitorings of ultrasound and field allowed instructor to provide prompt supports and ensure procedural safety by double check. These UGNB procedures were performed in 5–10 minutes without any clinical and mechanical problem.

Conclusions We developed telemedicine system for remote instruction of UGNB. This system could be used practically in clinical cases and might be useful to improve safety.

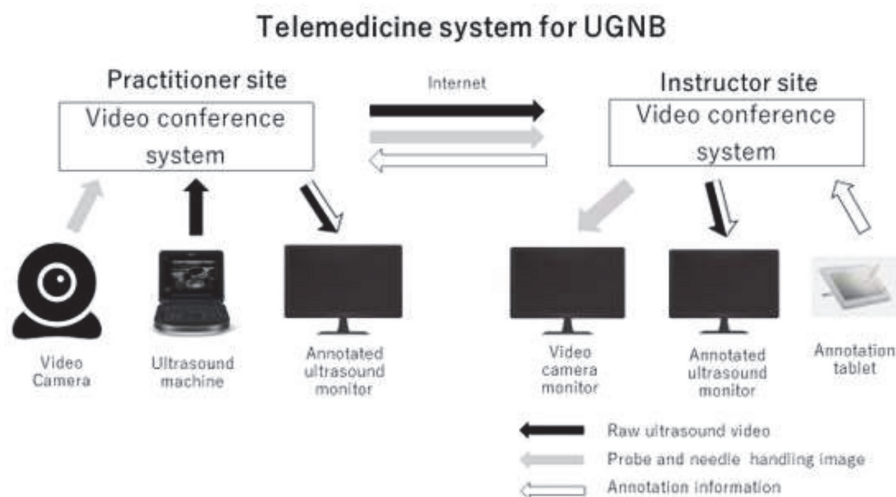
84 THORACIC INJURY PATHWAY TO OPTIMISE PAIN & PHYSIOTHERAPY

S Mohamedally*, B Fox. *Queen Elizabeth Hospital Kings Lynn, King's Lynn, UK*

10.1136/rapm-2021-ESRA.84

Background and Aims

- Evaluate the referral of rib fracture patients to anaesthetics/ acute pain team/physiotherapy & Critical Care Outreach Team (CCOT)



Abstract 83 Figure 1

- Pain management and use of regional techniques for these patients
- Offered PCA within first 24 hours
- Early physiotherapy – as soon as pain is controlled
- Early regional analgesia
- CCOT referral if mortality risk is high or NEWS >7

Methods

- Retrospective audit over the year 2019 at the QEHLK
- 80 patients coded as having a primary diagnosis of rib fractures – given Pressley Risk & Easter severity score.
- 29 patients scored moderate/moderate and above, 25 patients' paper notes were available – first 72 hours of admission was audited

Results

- Not achieving standard of care at 3 days
- Specialty input:
- Within 72 hours 80% had anaesthetics + physio reviews
- 5 patients weren't reviewed by any external teams
- All high risk of mortality patients are not getting a CCOT referral
- Pain management:
- 40% received PCA within 24 hours
- At 72 hours 64% of patients had a regional technique/PCA
- Regional techniques used were serratus anterior/erector spinae or thoracic epidural catheters. They were left in for an average of 4.4 days.

Conclusions

- Presented audit at information governance and teaching sessions for medical/surgical and A+E juniors
- Guideline revised with focus on regional anaesthesia
- TIPTOP Implementation:
- 1) Refer high risk thoracic injury patients to anaesthetic/acute pain team.
- 2) Book patient onto emergency theatre booking system
- 3) TIPTOP proforma to be completed by acute pain team/ anaesthetist to ensure follow up & standardised care
- Re-audit in 6 months time

85

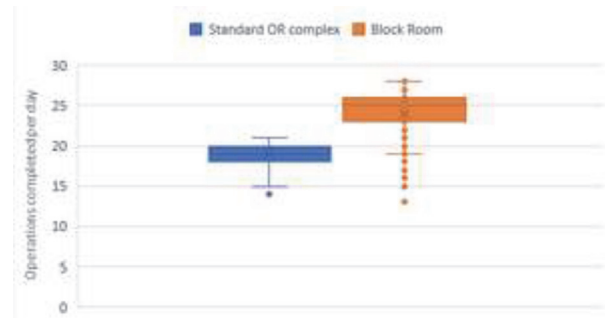
HOW SHOULD WE ORGANISE OUR BLOCK ROOM? USE OF SIMULATION MODELLING TO ASSESS THE EFFECTS OF IMPLEMENTING A BLOCK ROOM

¹J Wu*, ²A MacGregor. ¹Norfolk and Norwich University Hospital, Norwich, UK; ²University of East Anglia, Norwich, UK

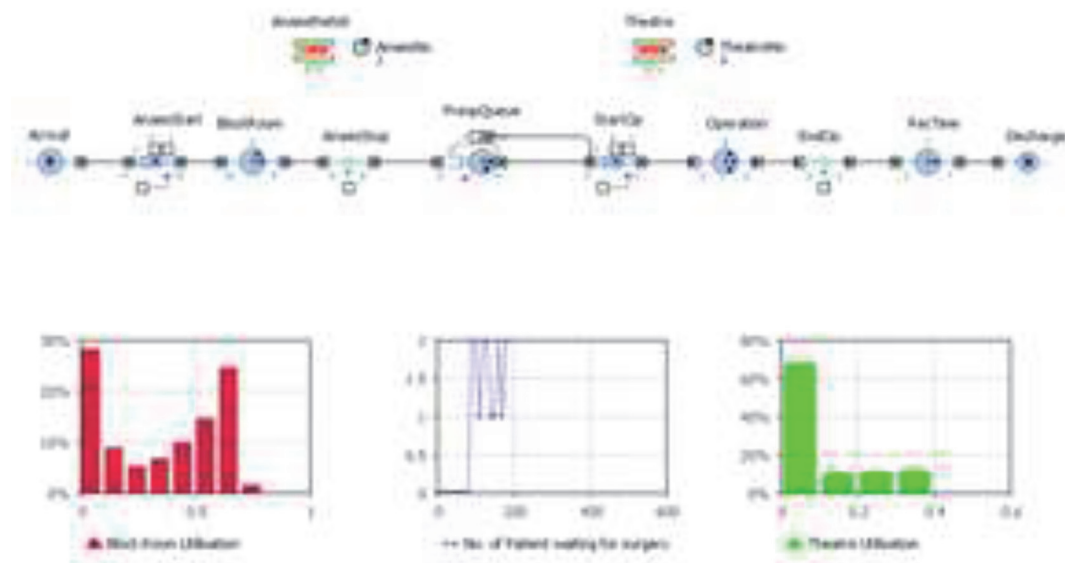
10.1136/rapm-2021-ESRA.85

Background and Aims Two models (example in figure 1) were created in AnyLogic 7 (The AnyLogic Company, 2015). One model simulates a standard operating room complex with three operating theatres, whilst the other model simulates a block room configuration with one block room supplying three operating theatres. The block room model was then used to assess changes in staffing. Each model was run 1000 times, to simulate 1000 work days.

Methods Two models (example in figure 1) were created in AnyLogic 7 (The AnyLogic Company, 2015). One model simulates a standard operating room complex with three operating theatres, whilst the other model simulates a block room configuration with one block room supplying three operating theatres. The block room model was then used to assess changes in staffing. Each model was run 1000 times, to simulate 1000 work days.



Abstract 85 Figure 2 Standard vs block room



Abstract 85 Figure 1 Example of block room model