

93 **INSTRUMENTED LUMBAR SPINE SURGERY UNDER SPINAL ANESTHESIA AND ERECTOR SPINAE BLOCK IN A STAGE IV LUNG CANCER PATIENT – A CASE-REPORT**

AP Martins Pereira*, FJ Moutinho Teixeira, JC Patrício Sampaio, M de Sá Rodrigues Moura Vieira. *Centro Hospitalar de Trás-os-Montes e Alto Douro, Vila Real, Portugal*

10.1136/rapm-2021-ESRA.93

Background and Aims Severe pulmonary conditions in patients undergoing surgery place them at greater risk of adverse outcomes and alternatives to general anaesthesia may be encouraged. Prone spinal surgery is customarily performed under GA. We describe the use of regional anaesthesia techniques to successfully circumvent post-operative pulmonary events in a patient with advanced disseminated lung cancer.

Methods A 63-year-old man, ASA IV, with debilitating stage IV lung cancer with pleural and mediastinic involvement, pulmonary artery invasion and adrenal, cerebellum and lumbar vertebrae metastatic disease, presents with severe disabling pain, in need for spinal surgery due to vertebral pathological fracture. After obtaining patient's consent, an ultrasound-guided bilateral erector spinae block at L2 level (with ropivacaine and dexamethasone) and a spinal blockade (with hyperbaric bupivacaine and sufentanil) were performed. IV infusions of low-dose propofol, ketamine and lidocaine were maintained during surgery.

Results Patient underwent uneventful L2 vertebroplasty and L1-L3 spinal fusion instrumentation. Quality and extension of the block were adequate and allowed surgery. Patient was comfortable during and after the procedure and safely discharged from anaesthesia care. Injury-related pain got manageable, and patient was satisfied with the approach. No postoperative complications were observed.

Conclusions In addition to several other reasons like decreased blood loss, less postoperative nausea and vomiting and better pain control comparing with GA¹, regional anaesthetic strategies appear to be useful alternatives for spinal surgery – including instrumented procedures – in patients with important pulmonary comorbidities, namely late stage lung cancer, who are at substantial risk for postoperative complications, avoiding further respiratory compromise in these frail patients.

94 **ULTRASOUND-GUIDED BOTOX INJECTIONS FOR ABDOMINAL MUSCULATURE RELAXATION TO FACILITATE LARGE VENTRAL HERNIA CLOSURE**

M Billstrand*, C Arndt. *University of New Mexico, Albuquerque, USA*

10.1136/rapm-2021-ESRA.94

Background and Aims We present a case of regional anaesthetists using ultrasound-guidance to strategically place Botox injections into the abdominal musculature to facilitate closure of a large ventral hernia. A male patient with complex abdominal surgical history that had previously failed abdominal wall reconstruction was scheduled for a reattempt at ventral wall closure and the surgeon consulted anaesthesiology for Botox injections.

Methods Three weeks before the surgery, the patient presented to anaesthesiology. His abdominal girth was measured at the umbilicus while relaxing (88.5cm) and while contracting (97cm) his musculature. Measurement of his defect across the umbilicus by palpation was 16cm. After monitors, IV placement and sedation the patient received Botox injections. Under



Abstract 94 Figure 1

ultrasound-guidance we identified three muscle layers; external oblique, internal oblique and transverse abdominis. We choose three sites per side for injection; a superior, middle and inferior site. Using a 22g Pajunk needle we placed 8 ml of Botox 2U/ml per muscle layer for a total of 300 units of Botox. The patient tolerated the procedure well.

Results At the time of surgery, the patient's abdominal girth at the umbilicus with relaxation was (91cm) and contraction (105cm). Palpation of the hernia was measured at the umbilicus at 19cm. Demonstrating relaxation of abdominal musculature. The patient proceeded to surgery with successful closure.

Conclusions As the technological advances in ultrasound have advanced so has ultrasound-guided regional anaesthesia and the role of the regional anaesthesiologist. We bring forward this case report as an example of regional anaesthesiologists' expertise being utilized outside the traditional setting to facilitate better outcomes for surgical patients.

95 **MOVING THE NEEDLE IN U.K. ANAESTHESIA TRAINING: THE INITIATIVE TO PROMOTE UNIVERSAL COMPETENCE IN REGIONAL ANAESTHESIA**

L Suntharanathan*, A Loughnan, D Tong, A Devlin. *King's College Hospital, London, UK*

10.1136/rapm-2021-ESRA.95

Background and Aims Historically regional anaesthesia has been an optional unit of UK higher anaesthesia training. However, 2019 U.K. day surgery guidelines recommend all anaesthetists should be familiar with regional techniques¹ and a recent *Anaesthesia* editorial proposed a list of 'Plan A' regional blocks, that all anaesthetists should be competent in².

These publications demonstrate the necessity for regional anaesthesia to develop from a subspecialist skill to an essential one. To reflect this, the incoming 2021 UK anaesthesia curriculum requires trainees to independently perform ultrasound-guided regional anaesthesia to receive a certificate of completion of training³.

We aimed to investigate the current level of training in ultrasound-guided regional techniques amongst higher trainees in our institution in line with the expectations of these publications.

Methods A survey of regional anaesthesia training and ability to perform ultrasound-guided regional techniques was