



Abstract 148 Figure 1

requirements post block. Ethical approval was sought for this project.

Results Approximately 71% of patients received a FIB, the main contraindication was anticoagulation. Levobupivacaine 0.25% was the local anaesthetic of choice. 87% of the blocks were performed by doctors, the remaining by advanced nurse practitioners. 92% were performed via the landmark technique. Approximately 77% of patients scored either moderate or severe pain pre-block, decreasing to approximately 18% post-block. Approximately 39% of patients required analgesia 12 hours post block, and the mean opioid requirements were 3 mg of oxycodone.

Conclusions There has been a significant increase in the number of FIB rates (71%) since 2018 when the average was 8%. Despite this improvement, there is still scope to increase the efficacy. The use of an ultrasound-guided technique will facilitate this change.

149

BRACHIAL PLEXUS BLOCK UNDER DEXMEDETOMIDINE SEDATION FOR SHOULDER ARTHROSCOPY

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Background and Aims Shoulder arthroscopic surgery is associated with significant postoperative pain and opioid consumption. Regional anesthesia is a valuable part of anesthetic management either combined with general anesthesia or as a sole anesthetic technique. However, surgery in beach chair position in an awake state increases patient anxiety and discomfort.

Methods We report a case of a 74-year-old male, ASA III, admitted for arthroscopic rotator cuff repair in an ambulatory setting. He had a history of chronic obstructive pulmonary disease (important bullous emphysema), smoking and past pulmonary tuberculosis.

Results Given the high risk of iatrogenic pneumothorax and postoperative pulmonary complications, we decided to avoid mechanical ventilation. We proceeded with a locoregional technique associated with dexmedetomidine sedation. An interscalene brachial plexus block (BPB) was performed under ultrasonography guidance (in-plane technique) with nerve stimulation. 20 ml of 1% mepivacaine were used.

150

THE EFFICACY OF THE ULTRASOUND GUIDED ICB NERVE BLOCK AND BRACHIAL PLEXUS NERVE BLOCK FOR UPPER ARM TRANSPOSED BRACHIAL-BASILIC ARTERIOVENOUS FISTULA IN VASCULAR ACCESS SURGERIES

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Background and Aims Transposed brachio basilic arteriovenous fistula (TBBAVF) is often used as an alternative for difficult AVF creation in the forearm or cubital fossa. The proximal site surgical incision close to the axilla frequently extends beyond coverage by a brachial plexus block (BPB) and often requires either rescue local anaesthetic (LA) supplementation or general anaesthesia. We report two cases that were successfully managed with an intercostal nerve block (ICB) and axillary brachial plexus block under ultrasound guidance.

Methods The Institutional Review Board's approval was obtained for these case reports. Two ASA III patients with similar comorbidities of hypertension, hyperlipidemia, diabetes mellitus and end-stage-renal failure, required TBBAVF due to their previous non-functioning AVFs.

An ICB nerve block (figure 1) and axillary BPB (figure 2) were performed under ultrasound guidance in both patients with Ropivacaine 0.25% 10 mL and 0.5% Ropivacaine 25 mL