

## 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.

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## 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.

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## 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

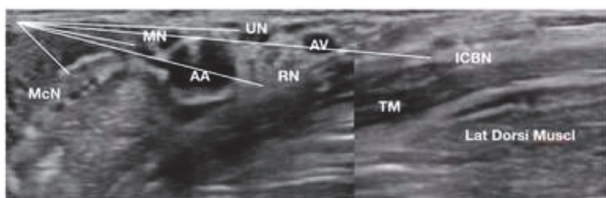
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**Background and Aims** Transposed brachio basilic arteriovenous fistula (TBBAVF) is often used as an alternative for difficult AVF creation in the forearm or cubital fossa. The proximal site surgical incision close to the axilla frequently extends 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



**Abstract 150 Figure 1 and 2** Ultrasound guided of axillary brachial plexus nerve block (AXB) and Ultrasound guided Intercostobrachial nerve block (ICBN). MN (Median nerve), UN (Ulnar nerve), McN (Musculocutaneous nerve), RN (radial nerve), TM (Teres Major muscle), AA (axillary artery), AV (axillary vein)



**Abstract 150 Figure 3** A continuous longitudinal incision over the basilic vein from the axilla to the medial epicondyle of the humerus for brachial artery to basilic vein anastomosis and anterior and superficial relocation of basilica vein

respectively with a BBraun Stimuplex 21G 100 mm insulated needle.

The surgery involved a continuous longitudinal incision over the basilic vein from the axilla to the medial epicondyle of the humerus for brachial artery to basilic vein anastomosis and anterior and superficial relocation of basilica vein (figure 3). Surgical duration was two hours.

**Results** The patients remained pain free intraoperatively with no supplemental LA required and completed uneventfully. Patients were discharged on the same day and the numbness resolved within 24 hours.

**Conclusions** We demonstrated how TBBAVF surgery is successfully managed by an ICB nerve block and axillary BPB under ultrasound guidance. Future studies are required to explore this technique, including dosage-finding study.

151 **SONOCLUB: INCREASING ACCESS TO REGIONAL ANAESTHESIA PLAN A BLOCKS**

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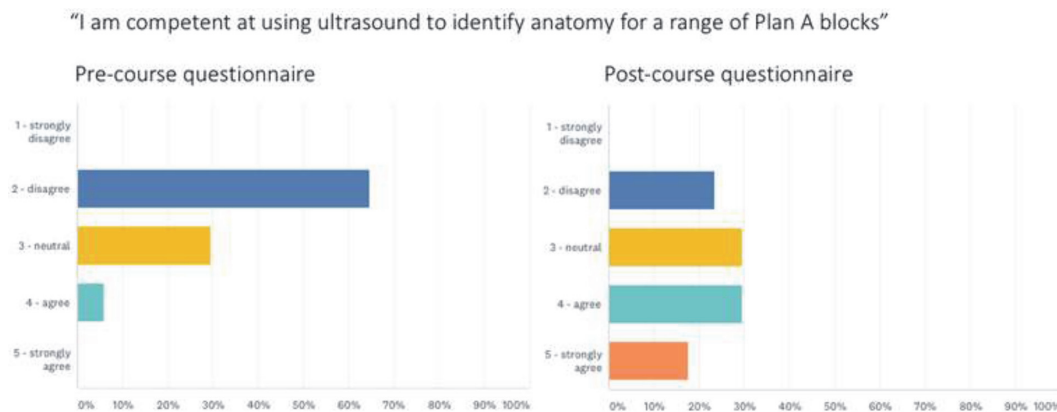
**Background and Aims** The new RCoA 2021 Curriculum requires anaesthetic trainees to ‘deliver a range of safe and effective regional anaesthetic techniques to cover the upper and lower limb, chest and abdominal wall independently’ [1]. RA-UK have highlighted inconsistencies in training and recommend core competency in high value Plan A blocks [2]. We implemented a weekly Sonoclub teaching program to cover all 7 Plan A blocks to raise the standards in ultrasound guided regional anaesthesia (UGRA) in our hospital (figure 1).

**Methods** Sonoclub sessions, which were organised by regional fellows from April to June 2021, lasted one hour encompassing lectures to help pass FRCA/EDRA and ‘block of the week’ scanning. Equipment included a computer, two ultrasound machines, two beds and willing participants. We conducted a pre- and post- course survey to evaluate trainees’ training and competency in regional anaesthesia.

**Results** 17 anaesthetic trainees (CT1-ST7) replied to the pre- and post- course questionnaire with an average attendance of 3 Sonoclub sessions. 24% agreed and 77% strongly agreed that Sonoclub improved their knowledge and skills in regional anaesthesia. Using a 5-point Likert scale, we found considerable improvements in the practice of obtaining consent, sonoanatomy of Plan A blocks (figure 2), managing complications

KNOWLEDGE	SKILLS
Ultrasound	Plan A - UL: Axillary
Complications	Plan A - Trunk: Erector Spinae Plane
Pharmacology	Plan A - LL: Adductor Canal
Consent	Plan A - UL: Interscalene
Anticoagulants	Plan A - LL: Femoral Nerve, FIB
Nerve stimulators	Plan A - Trunk: Rectus Sheath
Local anaesthetic toxicity	Plan A - LL: Popliteal Sciatic

**Abstract 151 Figure 1** Weekly Sonoclub timetable



**Abstract 151 Figure 2** Pre- and post-course questionnaire for sonoanatomy of Plan A blocks