

Bilateral: 1712 patients, two pneumothoraces. Complication rate 0.1%; 95% C.I. <0.01%, 0.4%

Conclusions Pneumothorax is a rare complication of ultrasound-guided PVB and serratus blocks in a high-volume practice. This aligns with the prior findings of Pace¹ in a retrospective study of 856 patients who received ultrasound-guided PVB, none of whom had suspected pneumothorax. We report a slightly higher rate of pneumothorax with serratus blocks, suggesting that fascial plane blocks are not necessarily 'safer.'

162

ULTRASOUND GUIDED SUPRACLAVICULAR BRACHIAL PLEXUS BLOCK WITH 0.5% BUPIVACAINE AND ADDITIVES: CASE SERIES AT TEACHING HOSPITAL ANURADHAPURA

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Background and Aims Supraclavicular block (SCB) is associated with excellent post-operative patient outcomes for upper limb surgeries. Bupivacaine, a long-acting regional anaesthetic, efficacy of which is altered with the co-administration of additives.

Aim of the study was to assess the efficacy of supraclavicular block with 0.5% bupivacaine compared to co-administration of additives and the associated complications.

Methods Following ethical clearance and informed consent, over a period of 5 months from June 2020, 152 adult patients at Teaching Hospital Anuradhapura Sri Lanka, undergoing upper limb surgeries were divided into 4 groups & prospectively followed-up. All received 0.5% of Bupivacaine while additives 2% Lidocaine, 8.4% sodium bicarbonate & 8 mg Dexamethasone was added to other 3 groups. Sensory and Motor block onset time, duration of post-block analgesia, acute and late complications and patient satisfaction was noted. Data was analysed using descriptive statistics & ANOVA, using SPSS V.25.

Results Successful surgical anaesthesia was achieved in all with 0 cases of long-term neurological complications with 94% patient satisfaction. The motor & sensory block onset time & post block analgesia duration respectively for Lidocaine (9.74min, 9.74 min & 7.07 h), Bicarbonate (12.89min, 16.32min & 12.09h), dexamethasone (19.34 min, 17.24min & 20.87h) & Bupivacaine was (20.39min, 18.42min & 13.15h).

Conclusions The differences between bupivacaine and lidocaine groups for sensory & motor block onset times & between Bupivacaine & dexamethasone groups for post-block analgesia duration were statistically significant ($p < .001$). Supraclavicular block has minimal associated complications & additives Lidocaine shortens the onset of anaesthesia and the duration of analgesia while dexamethasone prolongs the duration of analgesia significantly.

163

AN OPEN CONVERTED ABDOMINAL SURGERY IN ERAS (ENHANCED RECOVERY AFTER SURGERY) PROTOCOL

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Abstract 163 Table 1

	Patient 1	Patient 2
Drink water	H0	H2
Eat a rusk	H6	H6
Stand up & toilet	H6	H6
Intestinal transit	H36	H40
Catheters out	H36	H42
Discharge	H48	H96

Background and Aims Described by Forero et al, the Erector Spinae Plane Block (ESPB) is a multidermatomal sensory block that provides regional anaesthesia to the ipsilateral thoracic or abdominal wall.

We report two cases of Enhanced Recovery laparoscopic after sigmoidectomy converted to laparotomy, combining multimodal analgesia with bilateral ESPB for postoperative analgesia.

Methods The plan was general anaesthesia with minimal stress surgery care; using opioid free anaesthesia, dexmedetomidine, dexamethasone and NSAID. Early in the procedure, the surgeon converted to open surgery so we decided to keep the ERAS protocol with a bilateral ESPB which would ensure more comfort.

The ultrasound-guided injection of a long acting local anaesthetic between the erector spinae muscle and the transverse spinal process is followed by the placement of a catheter for continuous infusion (L-bupivacaine 0.125% at the rate of 6 ml/h).

Results The ERAS protocol was ensured. The Numerical Rating Scale scores were always below 3/10 except on day 2, at the withdrawal of the catheter relieved by 5 mg of oxycodone. No nausea or vomiting were reported. (Table 1)

Conclusions Bilateral ESPB is a safe technique with no major side effects compared to the epidural. It gives good quality analgesia and it provides a faster recovery with early standing so a good option in converted abdominal surgery. Prospective randomized trials are needed to confirm the apply of this block.

164

ANAESTHESIA AND POSTOPERATIVE ANALGESIA FOR FOREFOOT SURGERY – A REVIEW OF OUR CURRENT PRACTICE AT NOTTINGHAM CITY HOSPITAL

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Background and Aims Foot and ankle surgery are associated with moderate to severe pain which can influence the postoperative outcome. We performed an audit to review our practice for forefoot surgery at Nottingham City Hospital based

on the anaesthesia and analgesia principles outlined in the recently published PROSPECT (PROcedure SPECific Postoperative Pain Management) guideline for Hallux Valgus repair surgery.¹

Methods We performed a retrospective audit for patients who underwent forefoot surgery between 01/07/19 to 31/12/19. The data was collated from the Digital Health Records database, analysed in Microsoft Excel and presented at clinical governance meeting

Results A total of 102 patients underwent forefoot surgeries. Out of them, 68 patients had peripheral nerve blocks (PNBs) only, 30 had general anaesthetic alone or in combination with PNB or local anaesthetic infiltration (LAI) and 4 had only spinal anaesthetic. Ankle block was the most commonly performed PNB. Only 5% of patients received systemic paracetamol + nonsteroidal anti-inflammatory drugs (NSAIDs) and 26% received intraoperative dexamethasone. Discharge prescription were missing for 22% of the patients. Of those retrievable, 89% included an opioid to take home.

Conclusions As recommended in the guideline, the ankle block was PNB of choice. The majority of those who did not have an ankle block, had a popliteal sciatic nerve block and saphenous nerve block or LAI. However, there is scope of improvement in the use of intraoperative multimodal analgesia with paracetamol, NSAIDs and dexamethasone and appropriate discharge prescription for effective postoperative pain management.

166

THE EFFICACY OF MODIFIED THORACOABDOMINAL NERVES BLOCK THROUGH PERICHONDRIAL APPROACH: A PROSPECTIVE OBSERVATIONAL STUDY AND A CADAVERIC EVALUATION

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Background and Aims Modified thoracoabdominal nerves block through perichondrial approach (M-TAPA) was first described as a peripheral nerve block by Tulgar in 2019, which provides an analgesic effective range in Th7–11 with a single puncture per side¹. The efficacy and effective duration of the M-TAPA has been reported in several case reports; however its effects require further examination.

Methods With an IRB approval (No.2700) and registration (UMIN Clinical Trials Registry: UMIN000041137), 10 adult female patients scheduled for an open radical hysterectomy with vertical incision or laparotomy with a midline incision from under the xiphoid process to the symphysis pubis were enrolled. The primary outcome was the number of anesthetized dermatomes at 2 and 24 h postoperatively. Secondary outcomes included the numerical rating scale scores and the total amount of fentanyl used. Cadaveric evaluation was performed to assess the spread of the dye.

Results Patient characteristics are shown in table 1. The median number (interquartile range) of anesthetized

165

CONTINUOUS SUPRACLAVICULAR BRACHIAL PLEXUS BLOCK FOR REPLANTATION IN THE UPPER EXTREMITY – A CASE REPORT

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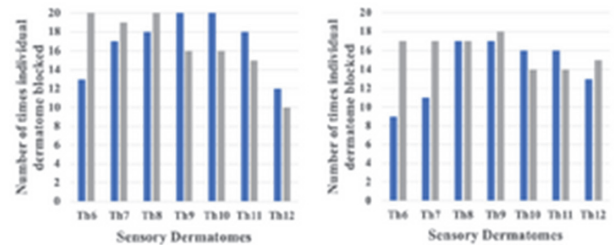
Background and Aims Continuous brachial plexus block (CBPB) with local anaesthetic is useful for long surgical operations on upper extremity. CBPC improve tissue perfusion after replantation surgery of the extremity by decreasing vasospasm, relieving pain, and promoting collateral circulation. In reconstructive surgery is particularly important because sympathetic blockade of the vessels provides increased blood flow to the injured extremity, which increases the success rate of the surgery.^{1,2}

Methods We present a case of a 51-year-old man, ASA 2, who had combined anaesthetic technique with continuous supraclavicular block of the brachial plexus to prevent postoperative pain and maintain extended vasodilatation.

The procedure was successfully completed under combined anesthesia.

Results In the reported case, CBPB was effective providing the best analgesia during the postoperative period and preventing the development of vasospasm in the digital arteries of the re-implanted digit and improving graft survival. The patient had a satisfactory evolution during the postoperative period, with adequate analgesia. No complications were reported.

Conclusions Microsurgical operation of the hand is a common procedure of reconstructive surgery. CPPB offers numerous advantages in terms of the best graft perfusion and was found to be effective in both sympathetic blockade and postoperative pain management.¹⁻⁴



Abstract 166 Figure 1

Abstract 166 Table 1 Patient characteristics

	All patients (n=10)
Age (years), median (IQR)	50.4 (43.5–58.5)
ASA grade (1/2)	3/7
Height (cm), mean (SD)	156±5
Weight (kg), mean (SD)	60±10
Duration of surgery (min), median (IQR)	241 (159–260)
Duration of anesthesia (min), median (IQR)	298 (193–322)
Intraoperative fentanyl use (µg/kg), median (IQR)	7.1 (5.7–9.5)
Time-weighted average of remifentanyl use (µg/kg/min), median (IQR)	0.18 (0.15–0.22)
Blood loss (mL), median (IQR)	728 (448–770)
Urine output (mL), median (IQR)	205 (155–270)
Total Input (mL), median (IQR)	3000 (2300–3383)
Pre-operative Albumin (mg/dL), mean (SD)	4.3±0.2
Type of surgery	
ATH+BSO+PLA+PALA+OMX	4
ATH+BSO+PLA	3
ATH+BSO+OMX	2
BSO+OMX	1