

the standard anesthetic choice despite being associated with postoperative complications. Regional anesthesia (RA) offers an alternative anesthetic choice. This study aimed to qualitatively review the literature on efficacy of RA alone for breast surgery.

**Methods** OVID and EMBASE databases were searched for articles pertaining to the use of regional anaesthesia alone for breast surgery up to June 2021. Systematic review was conducted according to PRISMA guidelines.

**Results** 24 studies were reviewed encompassing various RA blocks (paravertebral (PVB), pectoralis (PECS), thoracic and cervical epidural blocks (TEA, CE)). PVB represented 42% of studies. Mean patient age was from 54.8 – 72.6, most (65%) were ASA class 2–3. Two studies found the RA group had significantly less pain 24h after surgery, compared to GA.<sup>1,2</sup> Similarly, opioid and morphine equivalent requirements were significantly higher for GA compared to RA in two studies.<sup>3,4</sup> One study reported lower prevalence of pain in the TEA group versus GA. 3 Patients in the RA group had significantly less postoperative nausea/vomiting versus their GA counterparts, and greater level of patient satisfaction in two studies.<sup>2,4</sup> Rate of conversion to GA was 0% (95% CI [0%-3%]). No significant difference between length of stay or days till resumption of diet was found.

**Conclusions** There is substantial data to support the effectiveness of PVB as an alternative to GA for breast surgery. Such data was limited for PECS blocks, further studies evaluating efficacy of these blocks is warranted.

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#### CLAVIPECTORAL FASCIAL PLANE BLOCK AND SUPRACLAVICULAR NERVE BLOCK FOR REMOVAL OF OSTEOSYNTHESIS MATERIAL FROM A CLAVICLE FRACTURE. WHY NOT?

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**Background and Aims** Clavipectoral Fascial Plane Block (CPB) is most commonly used as an anesthesia and postoperative analgesia technique to clavicle fracture surgery. It consists in a local anesthetic injection under the clavipectoral fascia. The Supraclavicular Nerve from the Superficial Cervical Plexus is responsible for the sensory innervation of the skin that covers the clavicle, shoulder and superior region of the chest, It's blockage should complement the CPB.

**Methods** A 25-year-old male patient, ASA I, (weight 70 Kg, height 184cm) who underwent right clavicle fracture surgery under general anesthesia, was now scheduled for osteosynthesis material removal.

After obtaining informed consent to perform surgery under regional anesthesia, we performed an ultrasound-guided supraclavicular nerve block (SCB) and CPB with a total of 25 mL of local anesthetic (12.5 mL Ropivacaine 0,75% and 12.5 mL of Mepivacaine 2%), 5 and 20 ml were administered respectively. The CPB was performed with two needle punctures one at each side of the osteosynthesis material.

**Results** A satisfactory peripheral nerve block was achieved, and no complications were found. The patient remained calm and hemodynamically stable throughout the entire procedure.

**Conclusions** The combination of the CPB with the SCB is a safe and easy to perform procedure. It allows risk reduction

of phrenic nerve block as well as prevention of upper limb paralysis, when compared to brachial plexus block at the interscalene level. Other benefits are general anesthesia adverse effects avoidance, such as nausea and vomiting, sore throat, as well as airway manipulation.

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#### FEMORAL BRANCH BLOCK OF GENITOFEMORAL NERVE FOR FEMORAL ENDARTERECTOMY: A CASE REPORT

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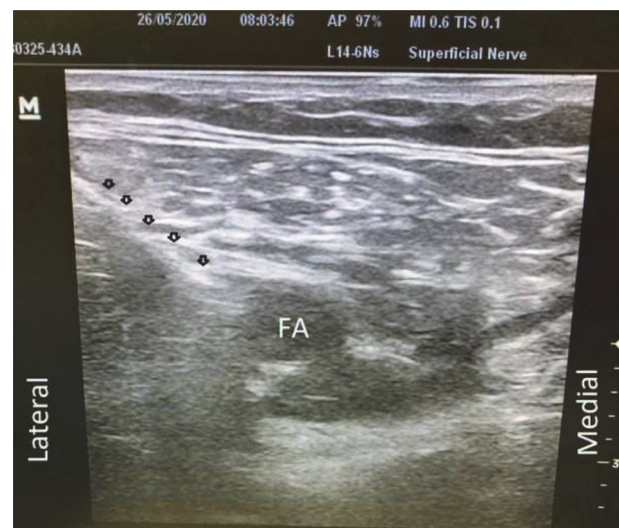
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**Background and Aims** Patients undergoing lower extremity vascular surgery are often at high risk for perioperative complications. We report a case of a high risk patient who underwent common femoral endarterectomy anesthetized by ultrasound guided femoral branch block of genitofemoral nerve (FBG) plus intravenous sedation.

**Methods** A 64 years old female patient was scheduled for common femoral endarterectomy and patch angioplasty. She had a history of congestive heart failure after myocardial infarction and chronic obstructive pulmonary disease. She was on dialysis three times a week, had echinococcal cyst in left lung, suffering from diabetic foot and was admitted to the hospital multiple times due to deregulated CHF. She was considered as high risk patient for general anesthesia. Her international normalized ratio (INR) was 1,7 so neuraxial anesthesia was contraindicated.

The FBG nerve provides sensation to the skin of the femoral triangle and to the underlying tissues and vessels within the femoral sheath. FBG nerve block was performed as a single peripheral nerve block for surgical anesthesia plus sedation. Using Mindray M7 ultrasound machine and L14-6Ns Linear transducer, the needle was inserted in plane to the sheath and 15 ml of 0,5% ropivacaine was injected, as shown.

**Results** Adequate surgical anesthesia was achieved 30 min later. Extra local anesthesia was needed for the incision close



Abstract 187 Figure 1

to the inguinal ligament, plus remifentanyl infusion (0,02–0,04 µg/kg/min) for sedation. The operation lasted 2 hours and the total administration of fentanyl was 2 µg/kg during the procedure.

**Conclusions** FBG nerve block plus local anesthesia can be an alternative for femoral endarterectomy.

### 188 REGIONAL ANAESTHESIA SERVICE: POWER TO THE PATIENT

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**Background and Aims** Regional anaesthesia is an integral part of elective anaesthesia in modern hospitals and is almost obligatory now for certain orthopaedic and general surgical procedures. There is increasing requirements for efficiency on surgical lists in UK hospitals. Our regional service uses regional specialists and fellows to perform nerve blocks for patients before their surgical procedure and whilst the surgical list can concurrently progress. We aimed to discover if patient's satisfaction was also being met with this service.

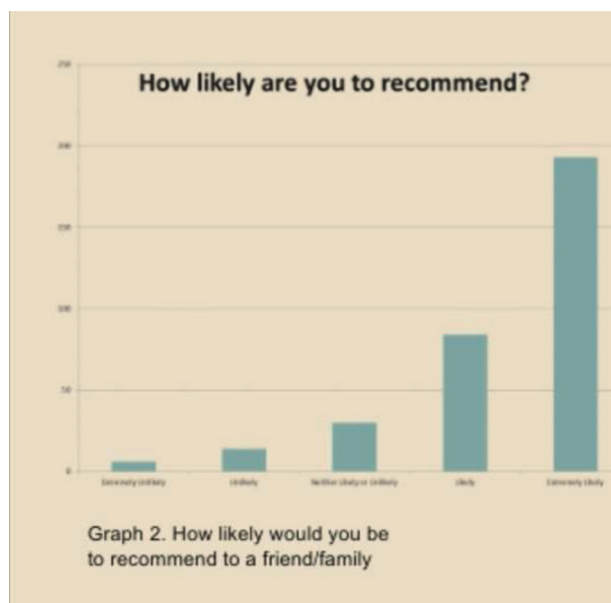
**Methods** All patients who went through the regional anaesthesia service from 2017 to 2019 had a follow up SMS to their mobile phone after 48 hours. This just involved the patients clicking a link and answering 6 questions on their experience of the nerve block with a free text box for any comments on regional recommendations. Automated email alerts were sent if there was anything concerning.

**Results** As primary endpoints, 58% stated that the pain block gave relief as expected and only 16% stating it was shorter pain relief than expected. 26% stated it lasted longer.

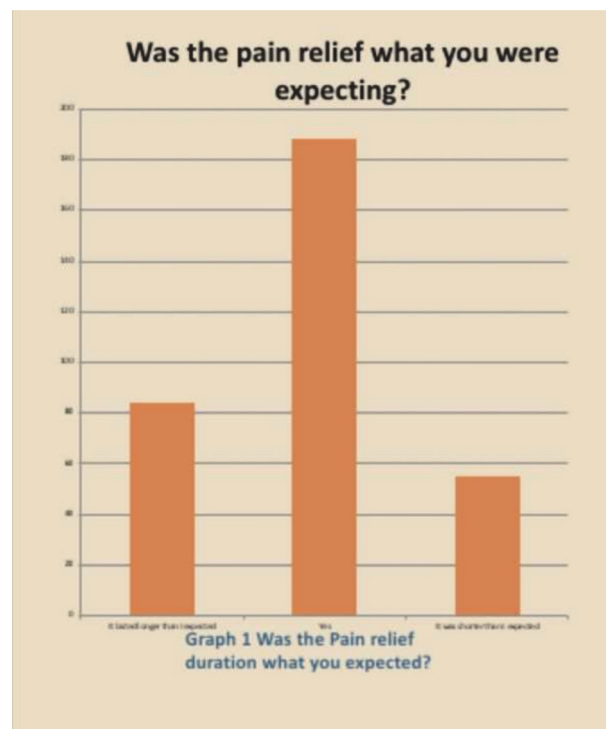
59% stated they were extremely likely and 26% likely to recommend to family/friends.

A few of the negative comments involved pain on injection and long lasting motor block being uncomfortable and annoying.

**Conclusions** We have found that regional anaesthesia follow up is beneficial for patient safety, satisfaction and service



Abstract 188 Figure 1



Abstract 188 Figure 2

improvement. There was overall a very positive response to regional anaesthesia and this has allowed us to make a business case for resources and funding.

### 189 A CASE OF HORNER'S SYNDROME AFTER ULTRASSONOM-GUIDED INTERSCALENE BRACHIAL PLEXUS BLOCK

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**Background and Aims** The brachial plexus innervates the upper limbs through roots from the cervical and thoracic nerves. Due to its anatomical location with proximity to other important nervous and vascular structures, which directly implies the occurrence of post-block complications. The purpose of this article is to review news evidence about the main complications of the interscalene brachial plexus block.

**Methods** Case report with bibliographic review of PUBMED with the descriptors 'interscalene block', without time limitation.

**Results** JFS patient, 61 years old, undergoes surgery to repair left rotator cuff injuries under interscalene brachial plexus block (Ropivacaine 0,5% 25 ml e Clonidine 75mcg) and sedation. Needle-guided ultrasound block Stimuplex® A50 (BBraun). The patient remained clinically stable throughout the procedure and was partially sedated to the recovery room.

When alert, the patient evolves with difficulties to communicate. On clinical examination, the patient presented hemodynamically stable with dysphonia and left eyelid prosis. Kept under observation and after 24 hours the reported symptoms were no longer present.

**Conclusions** Horner's Syndrome (HS) is a set of signs and symptoms due to the blockade of the ipsilateral sympathetic pathway that innervates head, face and eye. Manifested with