weight, levobupivacaine was diluted to 0.125% and 20 ml for each PECS block and 25 ml for each QLB block were administered, equaling a total amount of 90 mls. 1 g of paracetamol and 6 mg of morphine were also given.

**Conclusions** The procedure lasted 7 hours. Blood loss was 2 litres and the patient was transfused with 2 units of RBC. She was transferred asleep to HDU and woke up 4 hours later after postoperative haemodynamic stability was confirmed. She woke up feeling comfortable with a VAS score of 3/10. Combined QLB and PECS blocks can be a part of multimodal analgesia for extended thoracoabdominal incisions when epidural anaesthesia is not desirable.

**USE OF THE ULTRASOUND GUIDED ERECTOR SPINAIE BLOCK AS AN ALTERNATIVE ANESTHESIA METHOD IN A SELECTED VIDEO ASSISTED THORACOSCOPY CASE**

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Methods A 58 years old male patient who had a chest drain due to chronic right lung empyema after chemotherapy treatment due to lung cancer, was planned for diagnostic VATS and thoracoscopic diagnostic biopsy. In this case presentation, we present the application of ultrasound guided erector spinae block (ESPb) for the management of a VATS case as a main anesthesia method.

Methods A 72-year-old female patient, who had been taking oral tramadol, gabapentin and paracetamol due to pain in her left inferomedial gluteal region for 4 years, was scheduled for sacral ESPb. Formerly, the patient received piriformis injection twice, caudal injection twice in addition to a pudendal nerve block, and a pudendal nerve release surgery. High frequency linear transducer was placed on the fifth spinous process on the transverse plane when the patient was in the prone position. The transducer was then placed 3-4 cm lateral to the second medial sacral crest to visualise the intermediate sacral crest. In the interfascial plane, 20 mL of local anesthetic (10 mL bupivacaine 0.5%, 5 mL lidocaine 2%, 40 mg/2 mL methylprednisolon ve 3 mL normal saline) was injected between the erector spinae muscles and intermediate sacral crest.

Results The patient expressed relief of her pain after 5 minutes following sacral ESPb application. The third week of post-intervention period, she no longer required oral medication. The intervention was repeated after 6 weeks due to mild pain.

**CONCLUSIONS** Sacral ESPb may be a good option in cases with entrapment syndrome of posterior sacral nerve branches.

**NEW INDICATION FOR NOVEL BLOCK: SACRAL ERECTOR SPINAIE PLANE BLOCK FOR INFERIOR CLUNEAL/SACRAL NERVE ENTRAPMENT SYNDROME**

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Background and aims Inferior cluneal nerve entrapment syndrome (ICNES) is a rare and painful condition. Piriformis injections, piriformis release and caudal injections are used in the treatment. Herein, we report our successful application of sacral erector spinae plane block (ESPb) in a patient suffering from persistent ICNES.

Methods A 72-year-old female patient, who had been taking oral tramadol, gabapentin and paracetamol due to pain in her left inferomedial gluteal region for 4 years, was scheduled for sacral ESPb. Formerly, the patient received piriformis injection twice, caudal injection twice in addition to a pudendal nerve block, and a pudendal nerve release surgery. High frequency linear transducer was placed on the fifth spinous process on the transverse plane when the patient was in the prone position. The transducer was then placed 3-4 cm lateral to the second medial sacral crest to visualise the intermediate sacral crest. In the interfascial plane, 20 mL of local anesthetic (10 mL bupivacaine 0.5%, 5 mL lidocaine 2%, 40 mg/2 mL methylprednisolon ve 3 mL normal saline) was injected between the erector spinae muscles and intermediate sacral crest.

Results The patient expressed relief of her pain after 5 minutes following sacral ESPb application. The third week of post-intervention period, she no longer required oral medication. The intervention was repeated after 6 weeks due to mild pain.

**CONCLUSIONS** Sacral ESPb may be a good option in cases with entrapment syndrome of posterior sacral nerve branches.