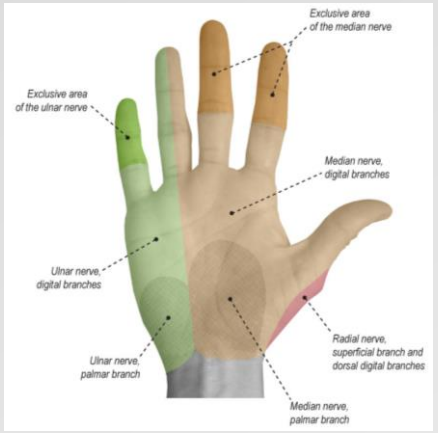
FOREARM (MEDIAN/RADIAL/ULNAR) BLOCK

INDICATION



NEEDLE

18g spinal needle

MONITOR

No need distal to elbow

VOLUME

"Tall": 5-8mL

PEARLS

- ❑ Block as proximal in the arm as convenience allows. The radial nerve in particular gives off perforating branches as you move distal. You will miss all these if you block distally, i.e. at the wrist
- ❑ Can often get two nerves in one poke. When blocking the radial (or ulnar) nerve, check to see if you can also get median nerve
- ❑ Can get needle very horizontal = great needle viz

PITFALLS

- ❑ Using too short of a needle
- ❑ Blocking only one of the three nerves. Adequate anesthesia will almost always require blocking two if not all three
- ❑ Osteotomes differ from dermatomes and generally require blocking much more proximally. This block will not work for FOOSH fractures
- ❑ Prescan your needle path to ensure no vasculature in the way

SCIATIC (POPLITEAL) NERVE BLOCK

INDICATION

NEEDLE

18g spinal needle

MONITOR

Yes, proximal to knee

VOLUME

"Grande": 10-15mL

PEARLS

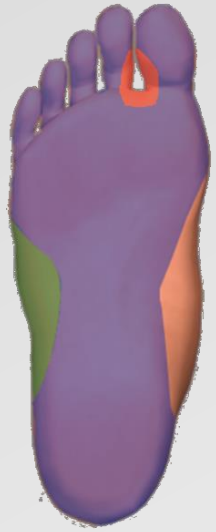
- ❑ Try starting 7cm (about one linear probe width) up from popliteal fossa
- ❑ Fan caudad due to anisotropy (and nerve running from deep to shallow)
- ❑ Watch for bifurcation, and block above (or be sure to block both nerves if below)
- ❑ If you're lost, try finding the peroneal nerve (coursing over fibular head) and follow it up

PITFALLS

- ❑ Using too short of a needle
- ❑ This block is particularly unforgiving to sloppy technique. Be sure you're in the perineural sheath. If you're not, there is always a large amount of popliteal fat tissue here, which will soak up your lipophilic Lidocaine and result in poor block
- ❑ Does not cover *entire* ankle (i.e. medial malleolus). May need to supplement with a femoral or saphenous n. block

POSTERIOR TIBIAL NERVE BLOCK

INDICATION



NEEDLE

20-22g regular needle

PEARLS

- ❑ May use in-plane approach (as with all other nerve blocks) or may use out-of-plane approach (as with PIVs) as logistics dictate
- ❑ With u/s you do not have to block low by the malleolus. You may follow the nerve proximal and block there if easier

PITFALLS

- ❑ Using too short of a needle
- ❑ Blocking the tendon instead of a nerve. This is a common mistake. Be sure to follow your target proximally to ensure it stays a nerve (and doesn't instead blossom into a muscle belly)

MONITOR

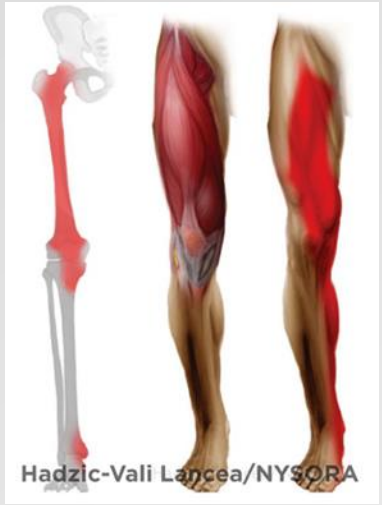
No need distal to knee

VOLUME

"Tall": 5-8mL

FEMORAL (FICP, 3-IN-1) NERVE BLOCK

INDICATION



NEEDLE

18g spinal needle

MONITOR

Yes, proximal to knee

VOLUME

"Venti", 20+ mL

PEARLS

- ❑ Be sure to appreciate two "pops", first fascia lata then second fascia iliaca. The femoral nerve will be deep to the fascia iliaca
- ❑ Go way lateral to make it a FICP if you prefer.
- ❑ Be sure to write on the patient and on the chart
- ❑ This is a large volume block. You may dilute your LA with saline if you want more mL
- ❑ Use linear probe if possible / body habitus allows

PITFALLS

- ❑ Using too short of a needle
- ❑ Using too little volume
- ❑ Be sure to *really* have good visualization of the entire length of your needle including bevel. If you're off by a couple degrees, it will look okay, but your tip will be deeper than you think. And there's a big artery there. And you have a large syringe of bupivacaine, the most cardiotoxic anesthetic!

"RAPTIR" (BRACHIAL PLEXUS) NERVE BLOCK

INDICATION

NEEDLE

18g spinal needle

MONITOR

Yes, proximal to elbow

VOLUME

"Venti", 20+ mL

PEARLS

- ❑ Good surgical anesthesia to most of the arm
- ❑ Pre-scan and make note of approximately what depth you should be visualizing the needle (like with chest tubes)
- ❑ Be sure to write on the patient and on the chart
- ❑ This is a large volume block. You may dilute your LA with saline if you want more mL

PITFALLS

- ❑ Using too short of a needle
- ❑ Using too little volume
- ❑ I would argue this block could *conceivably* mask a compartment syndrome
- ❑ Ensure benefits outweigh risks of this block
- ❑ Be sure to recognize location of pleura prior to procedure
- ❑ Be sure to aspirate prior to injection. Also, be sure to visualize wheal… if you can't see it, it's intravascular until proven otherwise