Pain thresholds in the warm (painful warm) and the cold (painful cold) temperature were lower in CD patients in both the upper and the lower limb compared to controls. There was a statistically significant difference between the two groups regarding the cold pain threshold (16.4°C±7.5°C vs 12.1°C±9.0°C, p=0.023) and a trend for a statistically significant difference regarding the warm pain threshold (41.9°C±3.2°C vs 43.3°C±3.3°C, p=0.067) in the upper limb.

Conclusions Asymptomatic young CD patients show abnormal pain thresholds compared to healthy controls. Cohort studies are needed to describe the natural history of neuropathic pain and PN development in these patients.

Conclusions The majority of referrals and blocks are performed out of hours which can introduce significant delays. We aim to implement a dedicated block service for catheter insertion during daylight hours, and provision of single-shot blocks out of hours with a view to improving early access to regional anaesthesia for chest trauma.

Case report

B187 SUCCESSFUL OUTCOME OF SPINAL ANAESTHESIA IN A PATIENT WITH A HISTORY OF SCORPION STING AND FAILED SPINAL ANAESTHESIA

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Background and Aims Scorpion stings can cause failure of spinal anaesthesia(1). We report a case of successful spinal anaesthesia with bupivacaine laced with adjuvant drugs in a patient with history of scorpion sting and failed spinal anaesthesia.

Methods A 26 years old gentleman with a history of scorpion sting at 2, 20 and 21 years of age was operated twice for fracture of right femur and left tibia. First time he was administered general anaesthesia after the failure of spinal anaesthesia with bupivacaine and fentanyl. 3 days later, he was operated again for tibial plating. This time, he was administered spinal anaesthesia with a combination of 1.5 ml of 0.5% bupivacaine heavy, 1.5 ml of 5% lignocaine heavy, 15mcg of clonidine (0.1 ml) and 7.5% sodium bicarbonate(0.2 ml) to make a total volume of 3.3 ml. Spinal anaesthesia was successfully established.

Results The scorpion toxins cause repetitive action potentials and persistent depolarization of sodium channels in nerve axons(2,3). An antigen-antibody response also may cause competitive antagonism of sodium channels.(1) We are not clear whether there is remodelling of the receptor resulting in resistance to local anaesthetics. Our presumption was that adjuvants can enhance the action of local anaesthetics and reverse this mechanism.

Conclusions In our patient with a history of scorpion sting and failed spinal anaesthesia, either one or a combination of the ingredients added to bupivacaine resulted in successful spinal anaesthesia.

B188 ERECTOR SPINAE PLANE BLOCK FOR SCAPULECTOMY – A SUCCESSFUL APPROACH


Background and Aims A shoulder surgical approach for total scapulectomy involves extensive anterior and posterior incisions, which affects C5-T5 dermatomes. An analgesic approach to the brachial plexus is insufficient, paravertebral or thoracic epidural blocks are more invasive and pectoral and serratus blocks cover only the anterolateral chest wall. The erector spinae plane block (ESPB) allows analgesia of the anterior, lateral
and posterior chest wall and also lower cervical roots, when performed at a high thoracic level (1,2,3).

**Methods** We present the case of a 64 years old male with a sarcoma of the left shoulder with scapular invasion, proposed for scapulectomy. After the surgery, under general anesthesia, the ESPB was performed at T3 level with 20 mL of 0.25% levobupivacaine followed by catheter placement. No pain ou complicaciones were in the immediate postoperative period as well as in the next days, reciving 20 ml mandatory bolus of 0.2% ropivacaine every 4 h and 1g of acetaminophen every 8h.

**Results** Considering our literature review, this is the first case described with the application of ESPB for post-scapulectomy pain control. We choose the T3 level in an attempt to achieve a C5-T5 cranio-caudal dispersion. Given the possibility that the uppermost dermatomes were not reached, the infiltration of the brachial plexus exposed by the surgical incision and superficial cervical block were also performed. With this technique, a pain and complication free postoperative period was achived.

**Conclusions** Being an anatomically easy and safe block to perform with ultrasound support, we consider that it could become the first option in regional analgesia for scapulectomy.

**Abstract B189 Figure 1**

Conclusions There is insufficient experience and evidence to suggest which intrathecal systems achieve best results1, nevertheless, lower gauge spinal needles may be alternatives when difficulties are encountered with technique performance.

**B190 PERIPHERAL NERVE BLOCKS IN ABOVE THE KNEE AMPUTATION: CAN THEY BE THE ONLY ANESTHETIC TECHNIQUE USED?**

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**Background and Aims** Above knee amputation (AKA) is associated with considerable mortality and morbidity. There is paucity of data describing the use of peripheral nerve blocks (PNB) as the sole anaesthetic technique in patients undergoing AKA.

**Methods** A 65 years old man (weight 60kg) diagnosed with diabetic ketoacidosis was found in cardiac arrest short after admission. Advanced life support was successfully performed. His medical history was significant for ischemic heart disease, heart failure, peripheral artery disease, chronic kidney disease and had an implantable defibrillator. A two-dimensional echocardiogram showed a 10% left ventricular ejection fraction. He was then transferred to the Intensive Care Unit. During his stay an acute limb ischemia was diagnosed. Unfractionated heparin was started, and he was proposed for a life-saving AKA. He presented to the operating room with non-invasive ventilation and vasopressor support. We performed echoguided subgluteal sciatic, obturator and femoral nerve blocks with 0.5% ropivacaine. Supplemental sedation with dexmedetomidine was used. The surgical procedure was uneventful and the patient remained hemodynamically stable.

**Results** We were left with few anaesthetic options. General anaesthesia was too risky in such an unstable patient. Subarachnoid block was contraindicated. We ended up performing regional blocks as the sole anaesthetic technique.

**Conclusions** Although challenging and sometimes requiring supplemental sedation PNB can be a viable option for AKA in high-risk patients.

**B191 OXYTOCIN FOR POSTPARTUM HEMORRHAGE AND ASSOCIATED VASOSPASTIC ANGINA: A CASE REPORT**

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