Abstract B189 Figure 1

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

B189 WHEN THE DURA GETS TOUGH, THE TOUGH GETS OXYTOCIN


Background and Aims Advancements in continuous spinal anaesthesia (CSA) equipment have been made, however, due to equipment inaccessibility, many institutions resort to epidural sets. We present a patient undergoing hip arthroplasty under CSA. Multiple unsuccessful attempts to access the intrathecal space (ITS) with a Tuohy needle were made. After an attempt with an 18-gauge spinal needle, the catheter was successfully threaded easily. In institutions that use epidural sets for CSA, lower gauge spinal needles may be successful alternatives to access the ITS when difficulties are encountered.

Methods Elderly female with aortic stenosis undergoing hip arthroplasty with CSA. Loss of resistance with an 18-gauge Tuohy needle was detected at 4cm. After unsuccessful attempts to access the ITS, an 18-gauge spinal needle was successfully advanced and a 20-gauge catheter introduced. Surgery was uneventful. She was discharged without cardiovascular complications or post-dural puncture headache (PDPH).

Results Differences in needle-tip design may have played a major role (Figure 1). Age-related calcifications of the dura mater may hamper dural puncture with a Tuohy needle’s gentle curved blunt bevel. A lower gauge spinal needle with a cutting bevel can access the ITS by facilitating dural tear, however, lack of markings make precise determination of the ITS-skin distance impossible. PDPH is a concern, however, it was not experienced, possibly due to lower incidences in the elderly and catheter-induced inflammatory reaction concealing the dural tear.

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

F Noqueira Machado, H Gouveia*, M Mendonça, M Luís, S Pereira, B Gonçalves. Hospital Central do Funchal, Funchal, Portugal

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 arterial 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 echocardiographed 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

F Yfantidis, E Garits*, T Maria, A Frapsou, E Logothetis. General Hospital of Volos, Anesthesia and Pain Management Department, Volos, Greece; General Hospital of Volos, Gynecology and Obstetrics Department, Volos, Greece

Background and Aims The current guidelines of the American College of Cardiology and the American Heart Association recommend a three-step approach for treatment of vasospastic angina: aspirin, heparin, nitrates. Narcotic analgesics are contraindicated for treatment of vasospastic angina.

Methods A 65 years old man diagnosed with type 2 diabetes mellitus and hypertension was found in cardiac arrest short after admission. The patient was a candidate for post-partum hemorrhage and associated vasospastic angina. The patient was treated with oxytocin, heparin and nitrates; however, the patient’s systolic blood pressure continued to drop and required vasopressor support.

Results The patient underwent a successful Cesarean section and was transferred to the Intensive Care Unit. The patient’s systolic blood pressure continued to drop and required vasopressor support. The patient was treated with oxytocin, heparin and nitrates; however, the patient’s systolic blood pressure continued to drop and required vasopressor support.

Conclusions The current guidelines of the American College of Cardiology and the American Heart Association recommend a three-step approach for treatment of vasospastic angina: aspirin, heparin, nitrates. Narcotic analgesics are contraindicated for treatment of vasospastic angina.

Abstract B191
Background and Aims Oxytocin is a neuropeptide hormone, normally produced by the hypothalamus and released from the posterior pituitary. Synthetic oxytocin is used to stimulate uterine contraction, in labor and in postpartum to control bleeding.

Methods An ASA II, 27-year-old woman was scheduled for an elective caesarian section. From her medical history, she has been diagnosed with an oligosymptomatic infection with Covid 19, a month ago and she underwent two caesarian sections in the past.

Results Under spinal anesthesia, a caesarian section was performed with delivery of a live male infant. After placental delivery we administrated 5UI of oxytocin. The patient was immediately transferred to surgery for fasciotomy, due to compartment syndrome. Surgery was performed under combined femoral and distal sciatic nerve block with ropivacaine 0.5% (50mg +50mg), under ultrasound guidance. No complications were reported intraoperatively and the patient was transferred to the Intensive Cardiology Unit. He was transferred back to the surgical ward the following day.

Conclusions Peripheral nerve blocks under ultrasound guidance can be a “game-changer” for the perioperative anesthetic management of patients with multiple comorbidities who must undergo an emergent surgery under antithrombotic therapy.

Background and Aims Peripheral nerve blocks can be the cornerstone of perioperative anesthesia management of patients with lower limb ischemia, who often present with multiple comorbidities. The aim of this case report is to present the perioperative anesthetic management of a patient with perioperative myocardial infarction, who underwent emergent fasciotomy, after embolectomy for the treatment of ischemia of the lower limb.

Methods An 89-year-old man presented to the emergency department with a massive abdominal wall hernia. Under spinal anesthesia, a caesarian section was performed with delivery of a live male infant. After placental delivery we administrated 5UI of oxytocin. The patient was transferred back to surgery for fasciotomy, due to compartment syndrome. Surgery was performed under combined femoral and distal sciatic nerve block with ropivacaine 0.5% (50mg +50mg), under ultrasound guidance. No complications were reported intraoperatively and the patient was transferred to the Intensive Cardiology Unit. He was transferred back to the surgical ward the following day.

Conclusions Vasopressor drugs may provoke similar angina events such as ephedrine, phenylephrine, ergonovine, oxytocin. Close attention to the patients’ symptoms, appropriate cardiac monitoring, and postdelivery cardiac assessment ensures timely recognition and subsequent management. Risk assessment for post covid patients must be included for further investigations.

Background and Aims Erector Spinae Plane Block (ESPB) is a novel analgesic method performed for numerous surgeries. This case report describes the performance of continuous bilateral ESPB for perioperative analgesia management of a high-risk patient who presented at the emergency department with a massive abdominal wall hernia.

Methods A 69-year-old, female patient presented at the emergency department with a massive abdominal wall hernia with inflammation and bowel necrosis. The patient was obese and suffered from hypertension, type II diabetes, heart failure, coronary disease and COPD. Our goal was to provide opioid-free anesthesia and we performed a bilateral ESPB along with placement of continuous infusion catheters at T10 level, under ultrasound guidance. An epidural block could not be performed as the coagulation laboratory tests were prohibitive and the body type of the patient was discouraging. After induction of general anesthesia, analgesia was guided by NOL monitor readings. Surgery included right hemicolecotomy and hernia repair with mesh. Intraoperative analgesia included Paracetamol 1000 mg and a bolus dose of Ropivacaine 0.2% (20 ml) to each ESPB catheter. No complications were reported perioperatively. Post-operative analgesia was achieved with Paracetamol along with bolus doses of Ropivacaine 0.2% (20 ml to each catheter) every 12 hours, for the first three postoperative days.

Results The bilateral ESPB contributed to the patient’s perioperative analgesia, mobilization and satisfaction.

Conclusions ESPB is a novel peripheral nerve block, which can be performed safely from an experienced anesthesiologist under ultrasound guidance and can serve as an alternative anesthetic plan providing excellent perioperative analgesia to high-risk patients undergoing major abdominal surgeries.