

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 or complications were in the immediate postoperative period as well as in the next days, receiving 20 ml mandatory bolus of 0.2% ropivacaine every 4h 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 craniocaudal 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 achieved.

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.

B189 WHEN THE DURA GETS TOUGH, THE TOUGH GETS GOING

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Background and Aims Advancements in continuous spinal anaesthesia (CSA) equipment have been made, however, due to equipment inaccessibility, many institutions resort to epidural sets¹. 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 concern², however, it was not experienced, possibly due to lower incidences in the elderly and catheter-induced inflammatory reaction concealing the dural tear³.



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 echo-guided 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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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 administered 5UI of oxytocin. In the next 2 min the patient complained of headache, chest pain, palpitations and on examination she had hypertension, tachycardia and some ESV's. No signs of ECG abnormalities (elevation ST, T) were noted.

We sedated the patient and controlled the hypertension with low doses of Trinitrate. In early postoperative period, troponinaemia and disorders of the ECG (depression ST V₃-V₆, prolonged QT, T elevated), were observed, therefore the patient was moved to the coronary department for evaluation. A cardiac ultrasound revealed a hypokinesia of basic interventricular septum and a mild mitral regurgitation. Next day, her cardiac ultrasound was normal but the troponinaemia persisted for 3 more days. The patient remained asymptomatic thereafter.

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.

B192 COMBINED FEMORAL AND DISTAL SCIATIC NERVE BLOCK FOR EMERGENCY FASCIOTOMY IN A PATIENT PRESENTING WITH PERIOPERATIVE MYOCARDIAL INFARCTION

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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 anesthesia 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 ischemia of the right lower limb, due to occlusion of right external iliac artery, common, superficial and deep femoral artery. His medical history included arterial hypertension. His preoperative electrocardiogram presented signs of ischemia, while the preoperative laboratory tests included increased troponin and creatine kinase levels and signs of acute kidney injury.

Results The patient was immediately transferred to surgery for embolectomy under monitored anesthesia care. After surgery,

the patient was transferred to the surgical ward, where triple antithrombotic therapy was initiated (LMWH, clopidogrel, acetylsalicylic acid), after cardiologic assessment.

The following day, the patient was transferred emergently 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 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.

B193 CONTINUOUS BILATERAL ERECTOR SPINAE PLANE BLOCK FOR THE PERIOPERATIVE ANALGESIC MANAGEMENT OF A PATIENT PRESENTING WITH MASSIVE ABDOMINAL WALL HERNIA WITH INFLAMMATION AND BOWEL NECROSIS

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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 hemicolectomy 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.