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 V1-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.

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 patients with multiple comorbidities who must undergo an emergent surgery under antithrombotic therapy.

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.