Background and Aims Continuous spinal anaesthesia (CSA) is used in orthopedics due to its advantage in immediate pain relief and anesthetic block achievement with minimal incremental anesthetic doses. Nevertheless, in the elderly, insertion is often difficult, attributed to bone spur formation or other anatomical irregularities. We present a case with deliberate dural puncture and intrathecal epidural catheter insertion after unsuccessful attempts for CSA.

Methods A 90 y, 46kg BW, 1.58m HT woman was admitted for intramedullary nailing of a subtrochanteric right femoral fracture. Her medical history comprised serious senile dementia, three previous operations, a recent transient ischemic cerebrovascular event and METs<4. Her labs were: Hgb 9.3g/dL, Hct 27.8%, PLTs 289000, PT 10.3sec, APTT 30.9sec and INR 0.96. CSA was attempted but after several attempts dural puncture was unfeasible due to spine deformities. A regular 18G Tuohy needle (Espocan®, B Braun) was inserted at L3–4 level and after CSF leakage at 6cm from skin, a conventional epidural 20G catheter (Perifix®, Soft tip, B Braun, Meslingen, Germany) was inserted and secured at 10 cm from skin, 1 ml 0.5% (5 mg) levobupivacaine was infused through an insulin syringe. An additional increment of 0.5 ml (2.5 mg) was needed to achieve a T5 anesthetic level.

Results No further dose was needed, neither hypotension was noted. The catheter was removed at the end of the procedure; sensory block lasted 3 h. No post puncture headache was noted.

Conclusions Deliberate dural puncture and intrathecal epidural catheter placement is a safe and efficient alternative when high gauge spinal catheter is difficult to insert.

Background and Aims Continuous spinal anaesthesia (CSA) is a promising and efficient technique providing excellent operational conditions.

Methods Patient written consent was obtained.

Results The authors describe the case of a 21-year-old healthy male patient scheduled for excision of a sacroccygeal pilonidal sinus. Surgery was performed under spinal anaesthesia, with multiple attempts at dural puncture with a 27G Whitacre and 25G Quincke spinal needles. Anaesthesia and surgery were uneventful with same-day discharge. On postoperative day 1, the patient developed occipital postural headache and a diagnosis of post dural puncture headache (PDPH) was made. Symptoms subsided within 8 days of conservative treatment. On postoperative day 11, the patient returned to the emergency department with complaints of blurred and double vision. Neurological examination was performed and a diagnosis of cranial nerve VI compression neuropathy was postulated. Occlusion therapy was prescribed and symptoms ceased by day 17 postoperatively.

Conclusions If CN VI palsy is an isolated neurologic deficit occurring within 3 weeks of dural puncture and preceded by a PDPH, it is likely a consequence of dural puncture leading to intracranial hypotension and CN traction.1 Conservative treatment is generally adequate to minimize patients’ discomfort and further investigation unwarranted if the deficit resolves spontaneously. It is important for anesthesiologists to be aware of this injury, to inquire about ocular symptoms and to educate patients and peers concerning this rare complication which can manifest within several days after postoperative discharge.

Background and Aims Cranial nerve (CN) VI palsy following spinal anaesthesia is a rare complication. The aim of this case report is to highlight this unusual injury to promote an adequate diagnosis and management.

Methods Patient written consent was obtained.

Results The authors describe the case of a 21-year-old healthy male patient scheduled for excision of a sacroccygeal pilonidal sinus. Surgery was performed under spinal anaesthesia, with multiple attempts at dural puncture with a 27G Whitacre and 25G Quincke spinal needles. Anaesthesia and surgery were uneventful with same-day discharge. On postoperative day 1, the patient developed occipital postural headache and a diagnosis of post dural puncture headache (PDPH) was made. Symptoms subsided within 8 days of conservative treatment. On postoperative day 11, the patient returned to the emergency department with complaints of blurred and double vision. Neurological examination was performed and a diagnosis of cranial nerve VI compression neuropathy was postulated. Occlusion therapy was prescribed and symptoms ceased by day 17 postoperatively.

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Background and Aims Lipodystrophic syndromes are congenital or acquired disorders, characterized by complete or partial
lack of adipose tissue. Apparent accumulation of fat in other regions of the body may be present. Metabolic complications resulting from lipodystrophy are severe insulin resistance, hyperlipidemia, progressive liver disease and increased metabolic rate. Treatment with leptin has been suggested with a potential role for both metabolic and reproductive health. We present a case of a parturient with lipodystrophy that underwent caesarean section.

Methods A 36 y G1P0 parturient with a history of congenital lipodystrophy, DM-1 since early childhood, hypothyroidism and hypertension during pregnancy was admitted. She had undergone partial lobar hepatectomy in the past. Before conception the patient had received leptin injections. Swollen lower extremities, hypertension (average BP 160/90) and increased urine protein were indicative of preeclampsia. At 33 weeks gestation signs of retinal detachment suggested caesarean section delivery. C-section was scheduled at 37 weeks. Preoperative BP was 184/95, HR 85, Sp02 98%. Epidural anaesthesia was chosen.

Results A total of 6 mL Lidocaine 0.2% (120 mg), 13 mL Ropivacaine 0.75%(97.5mg) and 50mcg Fentanyl were given through the epidural catheter achieving a T-4 anaesthetic level. BP was 150/80 until delivery and normal 120/80 afterwards. Oxytocin 5 iu bolus plus infusion was given as uterotonic. A solution of 0.15% ropivacaine with 2mcg/ml fentanyl in total of 200 ml was administered as post-caesarean section analgesic regimen.

Conclusions The choice of epidural anaesthesia for caesarean section in the rare case of a woman with lipodystrophy and hypertension during pregnancy was safe and efficacious.

B203 AWAKE MULTIMODAL ANAESTHESIA BASED ON EPIDURAL ANALGESIA FOR ORTHOSIGMOIDECTOMY: A CASE REPORT
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Background and Aims A 76-year-old patient was scheduled for laparotomic orthosigmoidectomy. The patient’s medical record included type-2 diabetes, dyslipidemia, COPD, venous insufficiency and tachyarrhythmias. He was a smoker of 30 pack years, with cough, hemoptysis, hoarseness and whizzing sounds bilaterally on auscultation. The thoracic x-ray showed a right-lung mass and a left lung atelectasy. The spirometry showed an obstructive pattern.

Methods The medical history of the patient, his clinical state and the severity of the operation made him high-risk for postoperative cardiac and respiratory complications. After the patient’s informed consent and discussion with the surgical team, awake multimodal sedation and analgesia, based on epidural anaesthesia, with local surgical infiltration was selected. An epidural catheter was placed in T10-T11 space. Test dose of 40mg lidocaine (2 ml) was administered, followed by administration of 8 ml of ropivacaine 0.2mg/ml and 50mcg of fentanyl.

The complementary medications that were administered are shown on the attached charts.

Duration of the surgery was 140 minutes.

Conclusions The combination of epidural anaesthesia, surgical field infiltration and opioid-sparing drugs could achieve an acceptable level of sedation and analgesia, for the performance of a laparotomic orthosigmoidectomy in a high risk patient, with a good level of postoperative pain management and avoidance of postoperative respiratory complications.

B204 RENAL CRYOABLATION UNDER ‘TOTAL REGIONAL’ ANALGESIA CONTEXT IN A NON OPERATIVE ROOM SETTING
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10.1136/rapm-2022-ESRA.279

Background and Aims Percutaneous CT-guided renal cryoablation is a safe and effective alternative to surgery for small renal cancer, feasible for fragile and elderly patients since it’s minimally invasive and ‘nephron-sparing’; it reduces pain, morbidity, length of hospitalization(4). It consists in ‘freezing’