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, SpO2 98%. Epidural anaesthesia was chosen.

Results A total of 6 mL Lidocaine 0.2% (120 mg), 13 mL Ropivacaine 0.75% (97.5 mg) 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
K Kyriazis*, D Karantoula, A Mourtzouchos, C Romana. Evangelismos General Hospital, Athens, Greece
10.1136/rapm-2022-ESRA.278

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 post-operative 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
M Mazzocchi*, B Mascia, G Bruschi, A Bersi, D Passador, F Quaretti. Foundation IRCCS Polyclinic San Matteo, Pavia, Italy
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(3). It consists in ‘freezing’...
the tumor through multiple Argon-gas probes, placed in the correct position under CT-scan guide. Absence of pain, required for patient cooperation in maintaining immobility and arm abduction during the whole procedure inside the CT-scan, is a challenge for the anesthesiologist.

Thoracic ESP block is performed by injection of local anesthetic in the fascial plane deeper than the ESP muscle, at the tip of the transverse process of the vertebra (T10); it provides visceral and somatic analgesia up to 6 vertebral levels downstream of the injection point(2).

**Methods**

Two patients (males, 68 and 83 yo) were scheduled for renal cryoablation; after a mild sedation with iv midazolam (2 mg) and sufentanyl (2–5 mcg), we performed an US-guided T10 ESP-block with a mixture of 0.25% levobupivacaine and dexamethasone 4mg. Before entering the CT-scan, we also performed an US-guided bilateral infraclavicular block (0.1%levobupivacaine 20 ml) to allow arm positioning.

**Results**

The procedures lasted about 180 minutes; no complication occurred, patients kept calm and cooperative during the whole time, with stable vital signs. NRS score at the end of procedure and during the following 24 hours was 0. Patients were both discharged at day 1.

**Conclusions**

The ‘total regional’ analgesia context has shown to be safe, effective and satisfying even in a non operative room setting.

---

**B205**

**PHRENIC-SPARING ANESTHESIA FOR SHOULDAR ARTHROSCOPY IN A COMPLEX POLYMORBID PATIENT: A CASE REPORT**

1M Mazzocchi*, 1B Mascia, 1D Passador, 1G Bruschi, 1F Riccardi, 1,2GA Iotti. 1Foundation IRCCS Polyclinic San Matteo, Pavia, Italy; 2University of Pavia, Pavia, Italy

10.1136/rapm-2022-ESRA.280

**Background and Aims**

The interscalene nerve block is an effective analgesic technique for shoulder surgery, but a common adverse effect remains the occurrence of ipsilateral phrenic nerve block (1). In fragile patients there’s the need to identify an effective but phrenic-sparing technique.

**Methods**

A 58yo patient with multiple comorbidities (Tab.1) and ‘frozen shoulder’ disease was scheduled for arthroscopy; his maximum right arm abduction degree was 30° and ordinary day activities were limited (he quitted working as a painter because of pain).

We performed a preoperative dynamic evaluation of phrenic activity with ultrasound that revealed impairment in left diaphragmatic function: decreased thickening fraction at rest and deep inspiration (12,5%), and decreased minimum thickening (0,16 cm).

We decided to perform a US- and ENS-guided right infraclavicular block with 0,5% Ropivacaine 30 ml + suprascapular block (posterior approach) with 0,5% levobupivacaine 10 ml and dexamethasone 4mg. During the procedure, sedation was obtained by infusion of a propofol-ketamine mixture (in a 1,5:1 ratio), with no hemodynamic changes.

**Results**

No complication occurred; there was no impairment in respiratory/coughing function, no need for intensive care recovery or support ventilation. Post-operative analgesia was obtained with acetaminophen and NSAIDS, there was no need for rescue analgesia (oxycodone).

**Conclusions**

Infraclavicular block with the association of long-lasting suprascapular block for post-operative analgesia is an effective and safe way to perform a phrenic-sparing anesthesia in complex patients at high risk for respiratory failure.