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 SHOULDER ARTHROSCOPY IN A COMPLEX POLYMORBID PATIENT: A CASE REPORT

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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.

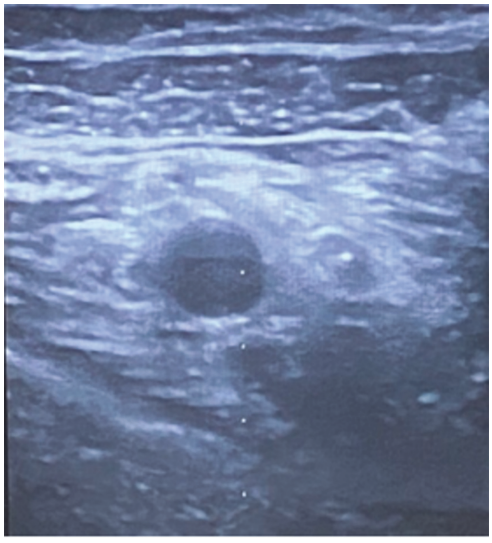
Methods A 58yo patient with multiple comorbidities (Tab.1) and 'frozen shoulder' disease was scheduled for arthroscopy; his maximum right arm abduction degree was 30° and ordinary day activities were limited (he quitted working as a painter because of pain).

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 infraclavear 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.

Abstract B205 Table 1

TAB. 1
Hypertension
DVT 2 years before
Clipping of MCA aneurism
Epilepsy
STEMI (multiple stenting)
Restrictive pneumopathy (VC – 30%)
OSAs
Phrenic impairment following spinal surgery



Abstract B205 Figure 1

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).

Abstract B205 Figure 2

Conclusions Infraclavear 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.