After the induction phase (propofol 30 mg and fentanyl 30 mcg) and IOT, ESPb was performed in right lateral position at the level of the transverse process of T3 with an ultrasound-guided injection of 10 ml Ropivacaine 0.15%.

**Results** Scleroembolisation procedure was performed after 20 minutes and lasted about 30 minutes, the patient presented a stable hemodynamic state, with excellent pain control. The maintenance of anesthesia was guaranteed with Propofol 0.09 mg/kg/min. No opioids were needed during the surgery. At the end of the procedure, Paracetamol 100 mg iv was administered. Upon awakening, the patient was extubated without complications and was pain free. Post-operative pain relief was not administered as the patient reported no pain. The postoperative pain control was 0 on the FLACC scale at 12, 24 and 36 hours and the vital parameters have always been valid and stable. The patient didn’t have PONV.

**Conclusions** The ESP block for scleroembolisation procedures could be considered a valid block for intraoperative and postoperative pain control in pediatric age. The analgesia covers almost the entire perioperative phase, significantly reducing the use of other analgetics.

**B212** **APERT’S SYNDROME: REFLECTIONS ON AN UNEVENTFUL SPINAL ANAESTHETIC FOR MAJOR LOWER LIMB SURGERY**

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**Background and Aims** Apert’s syndrome is a rare congenital disorder, characterised by premature fusion of the cranial sutures. Abnormalities of the skull, cervical spine, facial and tracheal architecture make airway management challenging. These and other musculoskeletal abnormalities and comorbidities can greatly increase anaesthesia risks.

**Methods** A 53-year-old lady with Apert’s syndrome presented for primary hip replacement. She had multiple previous craniofacial, foot and hand operations; several fused cervical vertebrae; and an emergency tracheostomy in the past. She reported difficult vascular access and difficulty breathing through the nose. Her BMI was 35. Due to the high risk of airway and respiratory complications, successful regional anaesthesia was deemed imperative.

**Results** Ultrasound was used to assist the successful performance of spinal anaesthesia. Low dose propofol by infusion was used as anxiolytic sedation. The two hour procedure was extremely well tolerated.

**Conclusions** This case highlights the importance of being able to apply regional anaesthesia as a sole technique, and the utility of ultrasound assistance for neuraxial techniques in potentially difficult patients. This relatively young patient is likely to require future lower limb surgery such as revision hip surgery. The patient’s positive experience, which has made future awake surgery more acceptable, and demonstration to future anaesthetists of the technique’s viability, was vital and was achieved.

In such patients, where significant comorbidities render general anaesthesia hazardous, regional anaesthesia techniques may be lifesaving. This will be ever more the case as our population’s burden of comorbidities increases and the epidemic of revision joint replacements is upon us.