

Abstract B214 Figure 2

Abstract B214 Table 1

Compartment of the leg	Anterior	Lateral	Deep post.	Sup. post.
Pressure (mmHg)	90	30	56	32

Results To also cover nervous supply from the femoral nerve we then did an adductor canal block (8 ml Levobupivacaine 2,5 mg/ml) and within five minutes the colour and pulsations in the foot were normalized. To secure vasodilation and analgesia nerve block catheters were inserted to the sciatic nerve and adductor canal. On day five the nails were exchanged for external fixation, fasciotomies closed and catheters withdrawn. External fixation was removed after three months. There were no complications. The patient and parents expressed satisfaction with the treatments and agreed to publication of this report.

Conclusions Fracture, vasospasm and ACS can occur concomitantly, especially in children^{1,2}. Nerve blocks to treat vasospasm is an interesting treatment modality, as in other cases of vasospasm^{3,4}.

B215 EPIDURAL HEMATOMA AFTER FAILED EPIDURAL CATHETER PLACEMENT: CASE REPORT

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Background and Aims Neuraxial techniques are highly-effective to improve multimodal analgesia. Serious complications are rare, more common with epidural, particularly epidural

hematoma(EH) and coagulopathy¹. Complication rates after failed neuraxial techniques are less known.

Methods 78-years-old woman submitted to open Whipple procedure with atrial fibrillation on warfarin. 5 days before surgery warfarin was discontinued and replaced by enoxaparin. Adequate stopping time of anticoagulation and normal coagulation and platelet were assured. Before GA,D11-D12 epidural catheter placement(ECP) was attempted by a senior anaesthesiologist, 3times without success. ECP was cancelled. No complications nor patient complaints. Patient was not referred to the acute pain unit(APU). Hospital Discharge(HD) home at 7thpostoperative day without neurologic symptoms. Enoxaparin anticoagulation started 6 hours after surgery. Warfarin initiation was scheduled.

Results 3 days after HD, patient went to emergency department with fever and abdominal pain. CT-scan revealed peritonitis and EH at the posterior portion vertebral canal, D12-L1 level, with spinal-cord compression. No neurologic symptoms. APU and neurosurgery evaluation requested. MRI confirmed EH diagnosis. Anticoagulation was stopped. Spinal compression signs were monitored. 5 days after, follow-up MRI revealed a EH size-reduction and no spinal-cord compression. Patient never reported neurologic symptoms. HD after 12 days with favorable neurologic progress. No neurologic deficits were reported. MRI showed complete resolution of EH.

Conclusions Clinical suspicion, particularly on anticoagulated patients, and careful monitorization since EH diagnosis is mandatory. Even with adequate anticoagulation drugs stopping time, normal coagulation function, EH may appear. In few asymptomatic patients close monitoring and MRI-scanning is enough. Surgical intervention may be necessary in the absence of symptomatic recovery or haematoma resolution.

B216 SPINAL EPIDURAL HEMATOMA AFTER EPIDURAL BLOCK: CASE ANALYSIS OF CONTRIBUTING FACTORS AND EFFECTIVE MANAGEMENT

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Background and Aims Spinal hematomas after neuraxial anesthesia can have devastating consequences. Increasing patient frailty may be involved in a growing incidence and early detection remains paramount in successful management. Through analysis of a clinical case, we aimed to identify possible factors involved in the occurrence and early detection of a spinal hematoma during epidural analgesia.

Methods A 76-year-old man with esophageal cancer, diabetes mellitus, obstructive lung disease and smoking history presented for elective esophagectomy. Surgery was performed under general anesthesia and a thoracic epidural block, and the epidural catheter was used for postoperative analgesia. On the third postoperative day, back pain and lower limb weakness prompted a spinal MRI, which revealed a T6-T8 epidural hematoma (Figure 1). Emergency laminectomy was performed, and the neurologic deficits subsided. Patient charts were reviewed and involved anesthetic personnel consulted for case analysis.

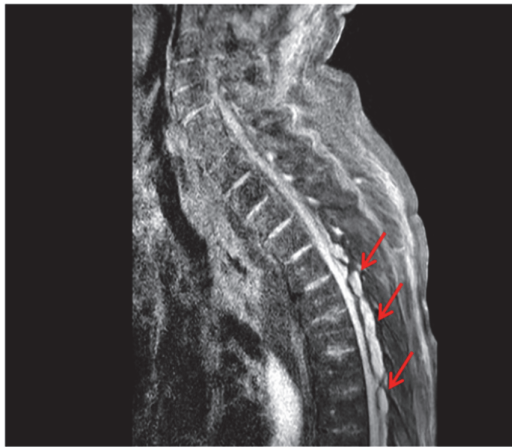


Figure 1. MRI with epidural hematoma compressing the spinal cord.

Abstract B216 Figure 1

Results Epidural placement was difficult and advanced thoracic spine osteoarthritis was later identified on spinal imaging. The postoperative course was also remarkable for euglycemic diabetic ketoacidosis, acidemia may have contributed to impaired epidural hemostasis. Other possible factors identified include preoperative thoracic chemoradiation, insulin-treated diabetes mellitus and frailty syndrome (Figure 2). Importantly, the acute pain service was decisive in expediting diagnosis and management, ultimately resulting in reversal of the neurological deficits.

Occurrence	Early detection
<ul style="list-style-type: none"> • Difficult epidural block • Spine osteoarthritis • Diabetic ketoacidosis • Thoracic chemoradiation • Diabetes mellitus • Patient frailty 	<ul style="list-style-type: none"> • Acute pain service • Trained floor nurses

Figure 2. Possible factors in hematoma occurrence and early detection.

Abstract B216 Figure 2

Conclusions Interaction between otherwise minor risk factors can contribute to spinal epidural hematoma after epidural block. Patient frailty, particularly, may represent an increasingly prevalent risk factor. Timely diagnosis and treatment are of the utmost importance, and acute pain services undoubtedly play a key role in active vigilance.

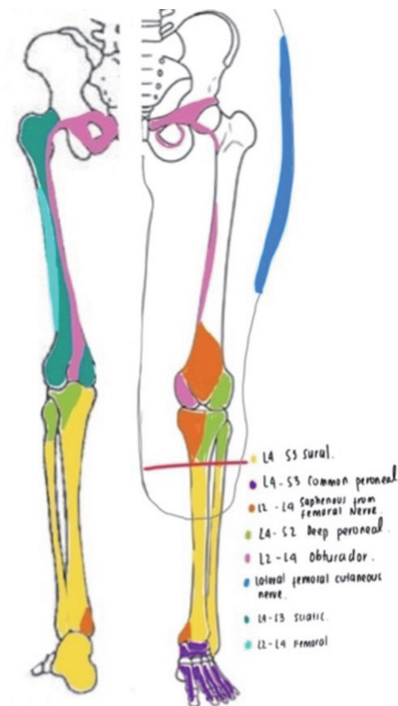
B217 REGIONAL BLOCKADES FOR LOWER LIMB AMPUTATION AS ANAESTHETIC APPROACH: TWO CASES REPORT

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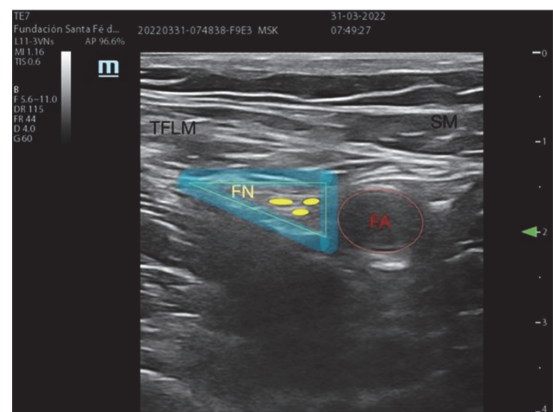
Background and Aims After lower limb amputation most patients experience severe acute pain (57% to 100%), multiple peripheral nerve blockades have been proposed as an anesthetic/analgesic technique(1). Sciatic nerve block (SNB) and

femoral nerve block (FNB) are regional approaches for those at risk to develop postsurgical chronic pain, including phantom limb pain(1 2). This regional approach may improve the outcomes compared with general anesthesia alone in high-risk patients by blunting surgery-related inflammation(1 3). The aim of this report is to show the effect of lower limb blockades as a sole anesthetic technique in two patients who underwent successful limb amputation.



Abstract B217 Figure 1

Methods Two cases of unilateral transtibial amputation in ASA III elderly patients (severe cardiovascular, pulmonary, and peripheral vascular diseases). Patient informed consent was obtained. Patients who underwent peripheral nerve blockades (sub gluteal sciatic, femoral at the inguinal crease, and femorocutaneous lateral nerve) were performed under a standardized ultrasound technique. Intravenous opioid Patient-controlled analgesia and non-opioid analgesics were administered.



Abstract B217 Figure 2 Local anesthetic distribution Femoral Nerve (FN)