Background and Aims Red Ear Syndrome (RES) is a rare disorder characterized by burning pain and redness of one or both ears. Since little to no knowledge exists regarding its etiology, pathophysiology and possible treatment, it remains an unsolved puzzle. We present the case of a patient suffering from RES who was treated in the Chronic Pain Management Clinic of University Hospital of Larissa.

Methods A 28 years old female patient referred to our chronic pain clinic due to disturbing, almost daily automatic flushes of her left ear, lasting from a few minutes to hours, accompanied by redness and burning pain. The initiation of the symptoms was noted after a period of recurrent upper respiratory tract infections, which were further complicated by ear infections. Her medical history revealed chronic headaches, respiratory tract infections, which were further complicated by ear infections. Her medical history revealed chronic headaches, respiratory tract infections, which were further complicated by ear infections. Her medical history revealed chronic headaches, respiratory tract infections, which were further complicated by ear infections. Her medical history revealed chronic headaches, respiratory tract infections, which were further complicated by ear infections. Her medical history revealed chronic headaches, respiratory tract infections, which were further complicated by ear infections.

Results After obtaining informed consent, we applied a greater auricular nerve block under ultrasound guidance. In total, four blocks of the greater auricular nerve were executed, in 6 weeks intervals. Of note, after the completion of the treatment, the prescribing doses of indomethacin and propranolol were reduced, while the everyday life activity of our patient was greatly improved and based on the Pain Outcomes Questionnaire her pain was reduced by 50%.

Conclusions The greater auricular nerve blockade was successful implemented for the management of the pain in a patient suffering from RES. Based on our experience it seems that the aforementioned PNB should be included in our toolbox when dealing with this obscure syndrome.

Background and Aims The perioperative anesthetic management of the vast majority of patients undergoing vascular surgery proves to be quite challenging, due to the multiple comorbidities. We present the case of a patient who underwent urgent axillofemoral bypass surgery, under Peripheral Nerve Block (PNB) and Monitored Anaesthesia Care (MAC) with bispectral index (BIS) values guiding the management of sedation.

Methods A 76 years old man, ASA III- IV, with critical lower limb ischemia, presented for urgent axillofemoral bypass surgery. Upon his arrival in the operation room dypnoea, use of accessory muscles and hypoxemia (SpO2: 81% on room air and pO2: 45 mmHg), due to a new-onset lower airway infection were noticed. From his past medical history coronary artery disease, diabetes mellitus type II, hypertension, hyperlipidemia, chronic kidney disease requiring dialysis, chronic obstructive pulmonary disease (COPD) and obesity were revealed.

Results Based on the aforementioned reasons, and mainly due to the concomitant lower airway infection, the avoidance of general anaesthesia (GA) was decided. Hence, after obtaining informed consent from the patient, the combination of PNB (ultrasound-guided supravclavicular and fascia iliaca blocks) with BIS-guided MAC (dexmedetomidine) were employed. The patient received supplemental oxygen therapy. The surgery was successfully completed after two hours and the patient was discharged without any awareness or any other complication from the post-anaesthesia care unit (PACU).

Conclusions PNBs combined with MAC and dexmedetomidine seems to be a reliable and safe alternative for axillofemoral bypass surgery when GA should be avoided.
Methods Surgery was performed under spinal anesthesia with levobupivacaine and sufentanil, patient was in light sedation with continuous propofol. Due to the distance from the implanted device to the operating field and by prior agreement with cardiologist, no magnet or bipolar cautery was used during the procedure. The patient was in the prone position for spongiosis retrieval from the left iliac crest and then supine for the removal of osteosynthetic material and intramedullary osteosynthesis. During the procedure, the patient was hemodynamically stable, in sinus rhythm, with intraoperative blood loss estimated at 500 ml. The uneventful surgery lasted for 2 h 45 min. The femoral nerve block was performed postoperatively, as per acute pain management protocol.

Results In PACU, the patient had an additional blood loss of 500 mL with onset of fast atrial fibrillation. Further management continued in the ICU with volume resuscitation and transfusion of PRBCs. The FA was converted to sinus rhythm with i.v. amiodarone in continuous infusion during next 24 hours. The following day the patient was referred to the ward with no further complications.

Conclusions In an increasing number of patients with implantable electronic devices a careful perioperative management may allow for timely intervention when required.

B224 PERIOPERATIVE MANAGEMENT OF A PATIENT WITH HEMOPHILIA A UNDERGOING TOTAL KNEE ARTHROPLASTY (TKA)


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Background and Aims Hemophilia A is an X-linked recessive bleeding disorder characterized by FVIII deficiency. Development of FVIII-alloantibodies is the major complication of hemophilia treatment, occurring in about 30% of these patients.

We report the perioperative management of a 30-year-old male patient with known history of severe Hemophilia A (FVIII <1%) and FVIII inhibitors proposed for elective TKA.

Methods Multidisciplinary optimization involved Orthopedics, Immuno-hemotherapy and Anesthesiology departments. Factor VII was initiated pre-induction and continued every 2h for 48h. General anesthesia was performed. Tranexamic acid was administered as a bolus (1g) followed by an infusion (1,5mg/kg/h), until the end of the surgery and adequate hemostasis was confirmed. A tourniquet was inflated. Before anesthetic emergence, a single-shot US-guided adductor canal block was performed using 25 ml of 0,2% ropivacaine and 1mcg/kg dexmedetomidine. Additionally, acetaminophen 1g, parecoxib 40mg, tramadol 100mg and ketamine 20mg were administered. Surgery was uneventful and estimated blood loss was 400 mL. Approximately 24h post-operatively he developed intense pain (8/10) refractory to intravenous analgesics. A continuous adductor canal block was performed with substantial pain relief (0/10), maintained at D3 post-operatively.

Results No major hemorrhagic complications were reported. Adequate analgesia allowed for early physical rehabilitation.

Conclusions Perioperative management of hemophilic patients is challenging due to the high bleeding risk requiring a multidisciplinary approach. Continuous adductor canal block, as part of a multimodal analgesic strategy, provided a safe and effective motor-sparing analgesic technique which enables faster recovery and enhanced patient outcomes.

B225 THE ANSWER TO THE DILEMMA OF THE UPPER ABDOMINIS WALL ANALGESIA? THE APPLICATION OF MULTIMODAL ANAESTHESIA IN A FRAIL PATIENT: A CASE REPORT

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