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. amiodaron 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.

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, Imuno-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.
Background and Aims A 59-year-old male patient affected by amyothrophic lateral sclerosis (ALS) was scheduled for open gastrostomy. He was tetraplegic with preserved sensitivity, breathing spontaneously and supported by NIV for 6 hours/night. The purpose of this report is to show the efficacy of the external oblique intercostal block in upper abdominal wall surgery.

Methods We placed a high-frequency probe (6–12MHz) in sagittal orientation along the mammillary line at the level of the 6th rib with the patient in supine position 30 minutes before surgery. A 21G x 80mm needle (Pajunk Sonoplex) was advanced in plane in cranio-caudal direction. We injected ropivacaine 15 ml 0.5% bilaterally opening the fascial plane between the intercostal and external oblique muscles, aiming for the anterior and lateral cutaneous branches of intercostal nerves T6 to T9/10.

Results During 80-minute surgery, the patient maintained spontaneous ventilation with supplemental oxygen (3 l/min). Comfort was provided by light sedation with propofol in TCI 1.0–1.4 μg/ml (Schnider) and staggered administration of fentanyl 150 μg. He remained hemodynamically stable and pain-free in the intra and immediate postoperative period with 1g IV acetaminophen 8-hourly and no rescue analgesia.

Conclusions The external oblique intercostal block is a recent fascial plane block for multimodal analgesia in the context of upper abdominal surgery and may be more effective than subcostal TAP block for the upper lateral abdominal wall. It is a safe technique due to the easy sonoanatomy and bony backstop and could be particularly valuable in frail patients or when general anesthesia and myorelaxation may be harmful.

Background and Aims Postoperative pain management in older patients is challenging due to several factors, including disease-related changes in physiology and disease-drug and drug-drug interactions (1). Inadequate treatment of pain is associated with undesired effects (2). However, the use of opioid drugs may also lead to complications in older patients (3).

Pericapsular nerve group (PENG) block is a novel block that targets articular branches of the accessory obturator nerve and femoral nerve, which has been shown to have a major role in the innervation of the hip capsule (4). In this case, we describe our experience with the continuous PENG block in an elderly patient.

Methods A 77-year-old ASA III woman with Alzheimer’s and Parkinson’s diseases was presented for hip surgery because of fracture. Following general anesthesia induction, PENG block was performed using an 80 mm needle with ultrasound guidance; 20 mL, 0.25% bupivacaine was injected in the space between the psoas tendon and the iliopubic eminence. At the end of the surgery, a catheter was inserted and infusion of 8 mL/h 0.1% bupivacaine was started, in addition 1 gr paracetamol and 20 mg tenoxicam was administered IV.

Results Patient was pain free in the postoperative 48 h period. No additional analgesic drug was needed and infusion was stopped after 48 h.

Conclusions This case showed that continuous PENG block via catheter provided pain free analgesia without the need of opioids in an elderly patient. However, we think that future randomized controlled trials are needed.