A successful hearing recovery after stellate ganglion block in a patient with third time unlucky: a tale of failing neuraxial anaesthesia.

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Background and Aims SSNHL (sudden sensorineural hearing loss) is common emergency in otolaryngologic clinic. Although spontaneous resolution has been reported as 32% to 65%, clinicians suppose these numbers might have been overestimated based on their experience. Moreover, if untreated with remaining hearing loss, SSNHL may cause significant depression and loss of their quality of life.

Methods A 36-year-old woman presented to our pain center complaining of incomplete recovery of hearing loss of right side of ear. Her initial audiogram demonstrated her air conduction threshold ranged between 45–65 dB and bone conduction threshold ranged between 80–50 dB while her left ear air and bone conduction threshold remained normal. We performed three sessions of right sided SGB with 2 weeks interval to the patient under ultrasound.

Results After 2 sessions of SGB, patient experienced subjective recovery of hearing loss, and confirmed of complete recovery of hearing loss by audiogram after the 3rd sessions of SGB. The patients’ audiogram was completely resolved. Both air and bone conduction threshold were less than 15 db.

Conclusions Therefore, the authors suggest that sono-guided procedure would be most adequate method of procedure of SGB to the patient with SSNHL. Adequate vasodilatation could be accounted by precise blockade of cervical sympathetic ganglion and leads to therapeutic effect of SGB on SSNHL. Ultrasound guided SGB could be an alternative salvage therapy for patient with refractory SSNHL.

B234 SCIENTIFIC NERVE BLOCK IN A PATIENT WITH CONGENITAL COMPLETE HEART BLOCK

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Background and Aims Patients with 3rd degree AV block undergoing surgery are more likely to develop severe bradycardia and hemodynamic instability increasing the risk of perioperative complications. Regional anesthesia is preferable for these patients as it is accompanied with minimal effects on the cardiovascular system. We present a case report of a patient with complete heart block undergoing urgent lower limb surgery under peripheral nerve block.

Methods A 43 years old man was admitted for Achilles tendon rupture repair. His history revealed nothing but a congenital known 3rd degree heart block. The patient was asymptomatic even during exercise, presenting an average heart rate of 40 bpm. After a thorough perioperative evaluation we decided to proceed with surgery, using intraoperatively isoprenaline if needed and having in position a temporary cardiac pacer in a case of hemodynamic instability. The surgery was conducted after a sciatic nerve block was performed, under ultrasound and nerve stimulation guidance, in parallel. A mixture of 1% lidocaine and 0.5% ropivacaine was used, and the patient was placed in the prone position.

Results Intraoperatively the patient remained hemodynamically stable, with a nonfluctuating heart rate of 40 bpm. The surgery was completed uneventfully, with no complaints of pain or discomfort. No cardiac complications were reported in the postoperative period.

Conclusions Peripheral nerve blocks remain a safe and useful anesthetic option for high-cardiac-risk patients. They provide minimal hemodynamic changes, excellent analgesic effects and fewer perioperative cardiopulmonary complications.

B235 THIRD TIME UNLUCKY: A TALE OF FAILING NEURAXIAL REGIONAL ANAESTHESIA

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Background and Aims We hereby present a case of a normally well 28-year-old primigravida, listed for a category 3 caesarean section (CS), who had multiple successful dural taps yet no adequate block.

Methods She was consented and sitting the spinal with 2.5 ml 0.5% ‘heavy’ bupivacaine was technically easy on first attempt. After 20 minutes, despite position optimisation, there was no motor or sensory block. A second spinal, with a new batch of bupivacaine, was sited at a higher lumbar space. This time, despite some objective lack of cold spray sensation to the L1 dermatome, no motor block was achieved. A decision was agreed to wait 2 hours and do a combined spinal epidural (CSE). Frustratingly, despite the CSE being straight forward to site, there was inadequate effect of the spinal anaesthetic. Cautious top ups of the epidural were given with...