

hypertension and cerebrovascular disease. Difficult airway predictors included Mallampati 4, OSA, short distances and large neck.

He was previously submitted to an open right hemicolectomy with GA. Towards the previous pathology and type of surgery, intensive care was required afterwards. Due to incision infection, re-intervention was required, resulting in a xypho-umbilical incisional hernia.

Two years later, he was scheduled for hernia correction. CSA was performed with standard monitoring (with invasive arterial pressure monitoring). The technique was conducted with a Tuohy epidural set (18G needle) and 3 cm of 20G catheter was introduced, cephalad oriented, without complications. A sensory T9 level was established with 5 mg of hyperbaric bupivacaine. Subsequently, a top up increment of 1mg of isobaric bupivacaine accomplished a sensory T6-L2 level, without haemodynamic instability. At the end of the procedure, a total of 3 mg isobaric bupivacaine was used and the catheter was removed. For postoperative analgesia, conventional analgesia without opioids was prescribed. He was discharged 4 days after, without neurologic complications or postdural puncture headache.

Results CSA allowed a sensory block suitable for the abdominal wall surgery with minimum impairment of the basal pathology of the patient.

Conclusions CSA is considered an alternative to GA for abdominal surgery in whom general anesthesia could increase morbi-mortality.

B233 A SUCCESSFUL HEARING RECOVERY AFTER STELLATE GANGLION BLOCK FOR SUDDEN SENSORINEURAL HEARING LOSS

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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 this 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 15db.

Conclusions Therefore, the authors suggest that sono-guided procedure would be most adequate method of procedure of SGB to the patient with SSNHL. Adequate vasodilation 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 SCIATIC 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 40bpm. After a thorough perioperative evaluation we decided to proceed with surgery, using intraoperatively isoprenaline if needed and having in position a temporary cardiac pacemaker 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 sited the spinal with 2.5 mls of 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