

Conclusions Intrathecal analgesia may be a successful short-term option for pain relief in opioid tolerant patients with acute postoperative refractory pain.

B239 WHEN THE PERIPHERAL NERVE BLOCK IS THE ONLY ANESTHETIC TECHNIQUE WHICH IS PERMITTED TO BE PERFORMED

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Background and Aims There are exceptional cases where both general and regional neuraxial anesthesia are contraindicated for specific patient groups (comorbidities and/or recent surgical interventions) posing, thus, a great challenge in the operating theater.

Methods We present the case of a 84-year-old multitrauma female patient who sustained an unstable fracture of L1 vertebra, fractures of right pleurae 10th-12th, bilateral fractures of the tibial bones, as well as abdominal, non-life threatening, injuries. She underwent urgent splenectomy, suturing of the liver, lumbar decompression laminectomy, closed reduction and internal fixation of the left tibia fracture and casting of the right one. She was hospitalized, thereafter, in the intensive care unit. Four weeks later, the patient was candidate for arthrodesis of her right ankle due to its comminution. She was respiratory and hemodynamically stable, tetrakinetic after the spinal surgery, but with delirium and sluggishness. The preoperative laboratory status revealed pathological values of TSH 61.4 mIU/L, FT3 1.5 ng/dl, FT4 0.7 ng/dl, ruling out general anesthesia, as an anesthetic option.

Results The operation was planned and successfully executed only with peripheral nerve block with the patient awake. The procedure was facilitated with an ultrasound guided saphenous and popliteal/sciatic nerve block with utilization of 0.5% 10 ml and 20 ml ropivacaine respectively.

Conclusions This case report demonstrates that peripheral nerve blocks could be the only feasible and sustainable anesthetic technique in a lower limb operation and their usefulness should be underscored when the traditional types of anesthesia are contraindicated, not technically performed and/or when the operation cannot be postponed.

B240 HORNER'S SYNDROME: AN UNDERESTIMATE COMPLICATION

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Background and Aims Horner's Syndrome (HS) results from a sympathetic nervous system dysfunction and is characterized by miosis, ptosis, facial anhidrosis, and conjunctival hyperemia. This is a rare complication in procedures performed by the anesthesiologist.

We present a case of a patient who developed a HS secondary to two possible rare causes: epidural anaesthesia or internal jugular vein (IJV) catheterization.

Methods 42 years old, female, ASA II, diagnosed with peri-prosthetic infection is proposed for complete resection of foreign material and placement of a spacer.

Combined epidural-general anesthesia was performed. The epidural blockade was performed uneventfully, at L3-L4 interspace. An ultrasound-guided central venous catheter (CVC) was placed in the right IVJ, without complications. The surgery was successful and postoperative analgesia was provided by PIEB with hourly boluses of 5 mL (ropivacaine 0.15% and fentanyl 1.5 µg/mL)

On the first postoperative day, the patient presented ptosis, miosis, and conjunctival hyperemia on the right side. It was assumed to be a functional HS caused by the epidural analgesia and the catheter was removed.

A week later, the patient maintained the clinical condition. It was concluded that HS was secondary to IVJ cannulation and the CVC was replaced with a left subclavian CVC.

Results HS remains a rare complication of IVJ catheterization. Direct needle puncture of the cervical sympathetic fibers or compression of these structures by hematoma was the two most common mechanisms.

Conclusions The rapid recognition of the condition allowed to consider different etiologies and their correction in order to limit the duration of symptoms and possible complications.

B241 DEVELOPMENT OF THE NAR EMINENCE COMPARTMENT SYNDROME DURING SPINAL SURGERY, AND MANAGEMENT UNDER REGIONAL ANAESTHESIA

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Background and Aims A 44-year-old gentleman was listed for emergency spinal cord decompression and stabilisation of the spine (T4-T9), having presented with cauda equina. He had a background of hypertension, anxiety, depression and BMI of 45 (185cm and 155kg).

Methods He underwent a general anaesthetic. He was difficult to bag-mask ventilate, given his high BMI and thick beard, and was a difficult intubation. Given the nature of the procedure and the need for the specialised spinal bed and O-arm in theatre, the patient's arms were required to be tightly wrapped. We ensured that the arterial line was reading and that intravenous access was maintained.

Following a successful surgery and uneventful anaesthesia, the patient was repositioned, awoken and extubated safely. He complained of severe pain localised to his right hand, even on passive movement. The thenar eminence was erythematous and swollen. Compartment syndrome of the thenar eminence was diagnosed.

Results There have been reports of loss of airway patency and failure to re-intubate patients that have been prone.¹ Voluntarily performing a repeat general anaesthetic was not felt to be the safest option due to him being a difficult intubation, and recent extubation with probable airway odema, and orofacial swelling following 6-hours of being prone. An emergency regional axillary block was performed, and he underwent emergency fasciotomy of his thenar eminence of the right hand.

Conclusions This interesting case demonstrates the need for careful attention to be given to patient positioning intra-