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 L1vertebra, 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 anesthesia 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 IJV, 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 IJV cannulation and the CVC was replaced with a left subclavian CVC.

Results HS remains a rare complication of IJV catheterization. Direct needle puncture of the cervical sympathetic fibers or compression of these structures by hematomas 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.
operatively, and the appropriate use of regional anaesthesia to provide the safest care for our patient.

**B242**

**BILATERAL ERECTOR SPINAЕ PLANE BLOCK AND CATHETER PLACEMENT FOR PAIN RELIEF IN A PATIENT WITH MULTIPLE RIB FRACTURE**

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**Background and Aims** Erector spinae plane block is a relatively novel approach to pain management for a variety of surgical procedures, as well as for acute and chronic pain. It is performed as a single injection block, or a catheter is placed for continued relief, and the procedure is most often performed with ultrasound guidance. Multiple rib fracture requires early intervention with adequate pain relief to prevent potential chest infection and prolonged hospital stay and, regional anaesthetic techniques are often a crucial component in analgesia.

**Methods** A 41-year-old female was admitted through A&E with Bilateral multiple rib fractures. The patient was trampled by a cow and sustained multiple injuries. Her CT scan reported clear lungs, with no pneumothorax or haemothorax. There were displaced rib fractures on the right side namely anterior 2nd and 3rd, antero-lateral 6th, postero-lateral 8th and 11th. Displaced rib fractures on the right side were anterior 3-6th ribs and postero-lateral 12th rib. Apart from this left clavicle fracture was fractured on medial one-third, T12 - L2 spinous process fracture, T12-L4 right transverse process fractures with significant displacement. Additionally, comminuted nasal bone fractures were reported. Bilateral erector spinae block and placement of catheter was performed under ultrasound guidance.

**Results**

**Abstract B242 Table 1**

<table>
<thead>
<tr>
<th>Hours after Block</th>
<th>VAS score</th>
<th>Rescue analgesia</th>
<th>Complication</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>6</td>
<td>3</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>16</td>
<td>6</td>
<td>PCM+ OM</td>
<td>Drowsy</td>
</tr>
<tr>
<td>24</td>
<td>5</td>
<td>PCM</td>
<td>None</td>
</tr>
<tr>
<td>32</td>
<td>5</td>
<td>PCM</td>
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</tr>
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<td>PCM</td>
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</tr>
<tr>
<td>48</td>
<td>3</td>
<td>PCM</td>
<td>None</td>
</tr>
</tbody>
</table>

PCM- Paracetamol OM- Oramorph

**Conclusions** Chest wall injuries are associated with significant morbidity and mortality, especially in patients with coexisting respiratory disease. Thoracic epidural, thoracic paravertebral, and intercostal blocks are available for the pain relief options, each has unique advantages and disadvantages. In our institution Erector spinae block and catheters are offered along with other options.

**B243**

**REGIONAL ANESTHESIA ROLE DURING LIMITATION OF LIFE SUSTAINING MEASURES – A CASE REPORT**

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**Background and Aims** Ethical dilemmas regarding the limits of perioperative medical interventions are growing concern in clinical practice. Increasing age and associated comorbidities along with anesthetic-surgical advances presents challenges when considering questions as “whether to operate or not?” or “how to impact minimally in fragile homeostasis?”.

**Methods** Our case report describes an 86-years-old man (Clinical Frailty Scale score 5) proposed to an emergent drainage of an intramuscular gastrocnemius abscess. Beyond their significant comorbidities (peripheral artery disease, ischemic cardiomyopathy) he was in septic shock with multiple-organ dysfunction (serum lactate 8.8 mmol/L). Intensive Care Unit (ICU) based-resuscitation team approached the patient in the ward and established a limitation of life-sustaining measures with refusal to be admitted in the ICU. However, in an expanded multidisciplinary team-meeting with Anesthesiology and Orthopedics, it was decided to operate under regional anesthesia (RA): sciatic nerve block with a popliteal approach.

**Results** The anesthetic cover of the surgical field allowed the source control. Thereafter, it was decided to implement fluid resuscitation and a vasopressor (noradrenaline 0.5 mcg/kg/ min). The patient exhibited a favorable clinical-laboratory response leading to a reassessment of the ICU admission.