

decision. He was admitted to an ICU-bed during 48h and transferred to a general surgical ward. After 52 days he was discharged.

**Conclusions** This clinical case highlights the role of RA in situations where invasiveness or aggressiveness of some intervention could overcome the acceptable risk for the patient. The RA allowed the surgical intervention with foci control whilst the additional interference with cardiovascular and respiratory systems was prevented.

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#### A PERIOPERATIVE MULTIMODAL OPIOID SPARING STRATEGY IN A PATIENT WHO UNDERWENT STERNAL RESECTION AND CHEST RECONSTRUCTION DUE TO BREAST CANCER METASTASIS

E Koutoulaki\*, V Nyktari, G Frantzeskos, P Vasilos, E Astyrakaki, A Papaioannou. *University Hospital of Heraklion, Heraklion, Greece*

10.1136/rapm-2022-ESRA.318

**Background and Aims** Sternal resection for selected patients with hemotogenous solitary sternal metastases by breast cancer might provide good long-term local control. Chronic post-thoracotomy pain is a serious and underrated condition warranting a continuing active pain management after discharge from hospital. A perioperative multimodal opioid sparing strategy for pain management after sternum resection and chest wall reconstruction due to metastasis is presented.

**Methods** A 53-year-old woman was scheduled for resection of manubrium of the sternum and chest wall reconstruction after diagnosis of a solitary sternal metastasis. The patient had a history of bilateral mastectomy for breast cancer 10 years earlier. Sternal defect was filled with an implant made of polyethylene.

**Results** A multimodal perioperative opioid sparing strategy resulted in adequate postoperative pain control. Follow up of the patient at 2 weeks, 1,2,3,6,9 months and one year revealed a localized dysesthesia and aching area under the clavicles. No other complications were noted, and the patient has returned to daily activities and work. A high level of satisfaction from adequate pain control was reported.

**Conclusions** Reconstruction procedures after sternum resection are difficult and burdened with significant complications including chronic pain development. A careful perioperative multimodal pain management strategy tailored to patients needs and wishes can prevent chronic pain development. The challenge is to identify patients at high risk of developing persistent post-thoracotomy pain and to create a targeted care pathway to ensure effective and safe pain treatment especially in the subacute postoperative phase at home.

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#### COPREHENSIVE SHORT-TERM METASTATIC HIP LESION PAIN MANAGEMENT WITH EPIDURAL ANALGESIA AND CONTINUOUS POSTERIOR LUMBAR PLEXUS (PSOAS COMPARTEMENT) AND SCIATIC NERVE BLOCKS DURING RADIOTHERAPY: CASE REPORT

<sup>1</sup>C Orfanou, <sup>1</sup>A Tsaroucha, <sup>2</sup>C Magklari, <sup>1</sup>I Koutalas\*, <sup>1</sup>A Tympa, <sup>2</sup>N Fyrliris. <sup>1</sup>First Department of Anesthesiology and Pain Unit Aretaieio Hospital, National and Kapodistrian University of Athens, Athens, Greece; <sup>2</sup>Agios Savvas, Anticancer – Oncological hospital of Athens, Athens, Greece

10.1136/rapm-2022-ESRA.319

**Background and Aims** A 49-years-old female patient presented at the Pain Clinic suffering metastatic hip bone cancer, after being diagnosed with breast cancer. She had undergone left mastectomy, radiotherapy and chemotherapy, before ending up with persistent right hip pain (NPRS 10), that initially was wrongfully attributed to her congenital hip dislocation. Radiotherapists requested relevant pain management, in order to achieve the appropriate lower limb position required for the radiotherapy.

**Methods** After a successful trial of posterior lumbar plexus (psoas compartment) block, that led to complete pain management, an unsuccessful placement of a percutaneous catheter of continuous infusion was attempted. Subsequently, an epidural catheter was placed at O2-O3 level and a test dose was administered uneventfully. Nevertheless, the patient's reaction to the first full ropivacaine dose suggested that a potential dural puncture had taken place, followed by spinal influx of the local anesthetic. That was also later confirmed by patient's manifestations and presence of air in the brain ventricles as depicted at the brain CT. Finally, the placement of a catheter of continuous infusion at the posterior lumbar plexus (psoas compartment) was achieved. After complaints of increasing neuropathic pain at the thighs' posterior surface, a second continuous infusion catheter was placed at the sciatic nerve. Both catheters were connected to 0.2% ropivacaine pumps.

**Results** Metastatic hip bone radiotherapy was achieved under complete analgesia (NPRS 0) of the local metastatic cancer pain.

**Conclusions** This case illustrates that complete short-term pain management of metastatic hip lesion is feasible through well-targeted pain management strategies.

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#### CASE REPORT: TOTAL FEMORAL REPLACEMENT IN A PATIENT WITH CHONDROSARCOMA. PERIOPERATIVE ANAESTHETIC MANAGEMENT WITH PERIPHERAL NERVE BLOCK

<sup>1</sup>C Magklari\*, <sup>1</sup>N Fyrliris, <sup>1</sup>S Pouloupoulou, <sup>2</sup>G Diakoumis, <sup>2</sup>I Papakostas, <sup>1</sup>T Lefaki. <sup>1</sup>Department of Anaesthesiology, General Anticancer Hospital of Athens "Saint Savvas", Athens, Greece; <sup>2</sup>Department of Orthopedics, General Anticancer Hospital of Athens "Saint Savvas", Athens, Greece

10.1136/rapm-2022-ESRA.320

**Background and Aims** Total femoral replacement (TFR) with endoprosthesis is a rare operation with few indications, primarily malignant bone tumors and requires extensive soft-tissue dissection and reconstruction of the joints.

Psoas compartment block (PCB) is a useful but controversial technique for lower limb surgery. There are often limitations due to essential antithrombotic therapy because of the risk of hematoma in this deep block, but the benefit of excellent analgesia outweighs the risk in major surgery.

**Methods** A 72 year old patient with recent pulmonary embolism (PE) under fondaparinux was presented for oncologic total replacement of the femur. Fondaparinux was discontinued for 48 hours preoperatively. A lumbar plexus block according to the Chayen approach was performed with 10 ml prilocaine 1% +20 ml ropivacaine 0.45% and a catheter was placed in the psoas compartment, combined with a single shot transgluteal sciatic block with 20 ml of ropivacaine 0.45% with the use of nerve stimulation technique. The duration of the surgery was 6h and was completed under general anesthesia