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.

**Background and Aims** Sternal resection for selected patients with hemoptoic 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.

**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 wrongly 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 (psosas 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 ropivacain 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 (psosas 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.

**Background and Aims** Total femoral replacement (TFR) with endoprostheses 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 sciotic 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.
without the use of opioids except the initial induction dose of 150 µg fentanyl.

The catheter remained for 4 days postoperatively with continuous infusion of 12 ml/h ropivacaine 0.2% by elastomeric pump.

**Results** The surgery was uncomplicated, the patient reported no severe pain (VAS 2–3), and didn’t require rescue opioid analgesia. He could move the other leg and manage to start his physiotherapy strengthening exercises.

**Conclusions** CPCB appears to be a useful alternative in major oncologic orthopedic surgery especially when neuraxial techniques should be avoided.

**B247** **MADELUNG’S DISEASE AND REGIONAL ANAESTHESIA’S TRUE ROLE – A CASE REPORT**

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**Background and Aims** Madelung’s disease is a rare condition, characterized by painless, diffusely distributed, non-encapsulated subcutaneous deposits (1).

**Methods** A 47-year-old male, proposed for a right inguinal hernioplasty on an outpatient basis. With a personal background of Madelung’s disease, painless lipomatous masses in the cervicofacial region and in the upper regions of the trunk, hypertension, and chronic alcohol habits. Evaluation of the airway showed limited cervical extension, lipomatous deposits around mouth, incomplete denture and an IV on the Mallampati scale.

A standard ASA monitoring was performed, O2 was placed under nasal cannulas at 3l/min, droperidol 0.625mg and fentanyl 0.05mg IV were administered. Subarachnoid spinal block was performed, between L3-L4, with Levobupivacaine 12.5mg and Sufentanil 2.5 mcg, positioned in left lateral decubitus.

**Results** After confirmation of block installation, the surgical procedure began lasting 45 min. Following the end of surgery, an ilioinguinal and right iliohypogastric block was performed, under ultrasound guidance without intercurrences. Patient’s analgesia. He could move the other leg and manage to start his physiotherapy strengthening exercises.

**Conclusions** This case report shows a patient with a possible bifurcation of left axillary was noticed. Terminal nerves surrounded both divisions, so the block was conducted by avoiding the vascular structures. On the right side, axillary artery continued as brachial artery. A total volume of 20 mL of 0.5% ropivacaine was injected. The patient did not develop any complication, especially related to vascular puncture. The procedure was uneventful. Postoperative analgesia was effective.

**Results** Anatomic vascular variations of the arm are not so rare. US improved safety and efficacy, detecting axillary artery variation and avoiding injection of local anaesthetic into vascular system.

**Conclusions** We report a case which enhances the guidance of ultrasound (US) during peripheral block, especially when vascular variations are considered.

**B248** **BIFURCATION OF AXILLARY ARTERY: A STUMBLING BLOCK DURING AXILLARY BLOCK**

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**Background and Aims** Axillary block is performed at the level of the terminal nerves of brachial plexus, which have a close relation with axillary artery (AA) and veins. Knowledge about normal and anatomic variants of AA is important for this block, since variations of the terminal end of the AA can occur in 14% of the cases. The main variation is a bifurcation in two major stems, instead of continuing as brachial artery.

**Methods** Axillary block was performed, with left Dupuytren’s contracture, presented for inpatient palmar fasciectomy. He had a previous history of a severe OSA with CPAP, insulin-dependent type 2 DM and psoriatic arthritis, classified as ASA 3. Regional anesthesia was considered more adequate for this case. A single shot axillary block, guided by ultrasonic (linear probe) was performed, with a 22G nerve stimulation needle. During the scanning, a bifurcation of left axillary was noticed. Terminal nerves surrounded both divisions, so the block was conducted by avoiding the vascular structures. On the right side, axillary artery continued as brachial artery. A total volume of 20 mL of 0.5% ropivacaine was injected. The patient did not develop any complication, especially related to vascular puncture. The procedure was uneventful. Postoperative analgesia was effective.

**Results** Anatomic vascular variations of the arm are not so rare. US improved safety and efficacy, detecting axillary artery variation and avoiding injection of local anaesthetic into vascular system.

**Conclusions** We report a case which enhances the guidance of ultrasound (US) during peripheral block, especially when vascular variations are considered.

**B249** **CONTINUOUS SPINAL ANAESTHESIA AND PERIPHERAL NERVE BLOCK – A WINNING COMBINATION IN SEVERE AORTIC STENOSIS**

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**Background and Aims** The main goals when managing patients with severe aortic stenosis are maintaining normal sinus rhythm and avoiding hypotension. All general anaesthesia and single-shot spinal are associated with significant hemodynamic changes, making them less than ideal options for these patients.1,2 Methods We report the successful use of continuous spinal anesthesia in a frail patient with severe aortic stenosis waiting for Transcatheter Aortic Valve Implantation (TAVI). An 83-year-old woman, ASA IV, was scheduled for urgent non-cemented hip hemiarthroplasty due to a femoral neck fracture. Her medical history included severe aortic stenosis (valve area of 0.50 cm2, mean valve gradient of 33mmHg), heart failure, coronary artery disease, atrial flutter, hypertension, diabetes, bilateral carotid stenosis, COPD, and recent pneumonia.

**Results** Once in the theatre, standard monitoring was started, and a brachial arterial line was placed. A femoral nerve block was performed with 0.5% ropivacaine (20 mL). An intrathecal catheter was placed and small doses of levobupivacaine 0.5% (up to 4mg) were administered (8.5mg total). A low-dose background infusion of phenylephrine was started at the time of intrathecal administration. The patient remained hemodynamically stable and comfortable throughout the procedure. The catheter was removed at the end of the surgery. Postoperative care continued in the level II unit for two days, with no complications.