

without the use of opioids except the initial induction dose of 150µg 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

P Camoes Correia, P Marques*, AL Veiga de Macedo. *Centro Hospital Universitário Coimbra, Coimbra, Portugal*

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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 interurrences. Patient's was transferred to the PACU, with paracetamol and opioid IV analgesia. The reversal of motor block occurred 2 hours after it was performed. The stay at PACU was uneventful, and the patient was discharged 6 hours after the surgical procedure with the criteria for outpatient surgery met.

Conclusions This case report shows a patient with a possible difficult airway presentation for ventilation and intubation (2). For these reasons regional anaesthesia should be considered on patients with Madelung's disease avoiding airway manipulation, decreasing the risk of complications, and allowing for an early discharge on outpatient surgeries.

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

¹N Carrillo-Alfonso, ²C Cruz Ferreira*, ³M Carvalho. ¹*Centro Hospitalar Universitário do Algarve, Faro, Portugal*; ²*Centro Hospitalar e Universitário do Porto, Porto, Portugal*; ³*Hospital Senhora da Oliveira, Guimarães, Portugal*

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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 62 year-old-male, 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 ultrasound (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

F Sales, C Pereira*, F Félix, M Cunha. *Unidade Local de Saúde de Matosinhos-Hospital Pedro Hispano, Matosinhos, Portugal*

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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. Both general anesthesia 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