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 was transferred to the PACU, with paracetamol and opioid IV on the Mallampati scale.

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 a physiotherapy strengthening exercises.

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

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 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 function. 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 anesthetic into vascular system.

Conclusions We report a case which enhances the guidance of ultrasound (US) during peripheral block, especially when vascular variations are considered.
complications. Postoperative pain was easily controlled with paracetamol and low-dose tramadol.

**Conclusions** Patients with severe aortic stenosis remain a challenge for anesthesiologists when presenting for orthopedic surgery. Continuous spinal anesthesia with peripheral nerve block is a safe and effective technique for these patients.

### B251 VITREORETINAL SURGERY WITH REGIONAL ANESTHESIA IN PATIENTS WITH SEVERE THORACIC KYPHOSIS AND MULTIPLE PULMONARY CO-MORBILITIES

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**Background and Aims** The majority of the ophthalmic surgeries are done in day case setting in elderly patients with multiple co-mobilities. It is fundamental that the patient can lay flat comfortably during surgery with no movement if regional anesthesia (RA) is planned.

**Methods** We report a vitreoretinal surgery with RA. The patient had multiple respiratory co-morbidities, including diabetes, hypertension, and asthma. The patient was ASA III with severe thoracic kyphosis and multiple pulmonary co-morbidities. The patient was planned for spinal anesthesia with peripheral nerve block.

**Results** The surgery lasted two hours and 10 minutes, without complications. Postoperative pain was easily controlled with paracetamol and low-dose tramadol. The patient was discharged on the day of surgery with a good operation field. Even though, there are descriptions of the use of only one of the above blocks to perform RA in vitreoretinal surgery, with both blocks the patient is more comfortable and more likely to tolerate a long surgery.

### B252 COMBINATION OF PERIPHERAL NERVE BLOCKS IN A PATIENT WITH EISENMENGER SYNDROME

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**Background and Aims** Patients with Eisenmenger syndrome undergoing non-cardiac surgery consist of a great challenge regarding anesthesia management. Both general and neuraxial anesthesia can cause acute shifts in the arterial pressure and excessive hemodynamic changes, leading to potential hazardous results. We present a patient with Eisenmenger syndrome undergoing urgent lower limb surgery under peripheral nerve block.

**Methods** A 62 years old female was admitted for surgical repair of a trimalleolar fracture. Her medical history revealed Eisenmenger syndrome due to congenital Ventricular Septal Defect (VSD), with severe pulmonary hypertension (70–75mmHg). In room air conditions she maintains SpO2 and pO2 values of 83% and 56mmHg, respectively. Sciatic and femoral nerve blocks were performed under ultrasound guidance and concurrent use of nerve stimulator, administering 15 ml of ropivacaine 0.5% at each block site. The patient was then placed in prone position for 2 hours until the end of the surgery. Invasive arterial blood pressure monitoring was used while 2mg of midazolam were used as an anxiolytic agent.

**Results** Intraoperatively the patient remained hemodynamically stable, and the surgery was completed uneventfully. The patient experienced no pain, reporting minor discomfort due to the prolonged prone position. Postoperatively no supplemental analgesia was required while no complications were reported.

**Conclusions** Peripheral nerve blocks in high-risk cardiac patients constitute a safe and efficacious alternative technique for anesthesia management. They offer hemodynamic stability, along with satisfactory postoperative pain scores and less perioperative complication rates.