

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.

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SPHENOPALATINE GANGLION BLOCKS FOR TREATMENT OF POST DURAL PUNCTURE HEADACHE

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Background and Aims Post dural puncture headache (PDPH) is a known and potentially debilitating complication of neuraxial anesthesia that can impede patient recovery. The conventional treatment includes hydration and symptomatic treatment like simple analgesics. Those who have unremitting symptoms following conservative measures are offered an epidural blood patch (EBP). However, EBP, an invasive procedure is associated with many complications.

Methods We report a 40 year old man who experienced PDPH after spinal anaesthesia. His symptoms recurred after conservative managements was instituted was offered a trans nasal sphenopalatine ganglion (SPG) block.

Results He had excellent pain relief and did not require an EBP.

Conclusions SPG blocks can be considered early in the treatment of PDPH together with general supportive measures. However, if pain relief is not achieved, an epidural blood patch should still be considered.

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VITREORETINAL SURGERY WITH REGIONAL ANESTHESIA IN PATIENT 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-morbidities. 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.

Results A 80 year-old women, ASA III with severe thoracic kyphosis because of bone tuberculosis causing restrictive pulmonary syndrome, bronchiectasis and sleep apnea with nighttime BiPAP and oxygen therapy during the day, was proposed to vitrectomy because of retinal detachment.

On account of the risk of general anesthesia (GA) in this patient, we decided to perform a peribulbar block and a sub-tenon block with 1% ropivacaine, 3,5 ml and 3 ml respectively. To achieve adequate positioning there was a need to use multiple pillows until the patient was comfortable, and the surgeon satisfied. To complement the local anesthetic, we used a light sedation with alfentanil.

The surgery lasted two hours and 10 minutes, without complications.

Conclusions In our case, the patient had multiple respiratory co-morbidities with high risk of complications in case of a

GA. She also had a severe kyphosis with need of creativity to achieve adequate positioning. With a good communication with the nursing team and the patient we were able to attain 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.

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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 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 blockade.

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 maintained 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.

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SPINAL ANAESTHESIA IN A PATIENT WITH HUNTINGTON'S DISEASE – A SAFE TECHNIQUE

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Background and Aims Huntington's Disease (HD) is a rare autosomal dominant neurodegenerative disease with a distinct phenotype, including chorea, dystonia and cognitive decline.¹

There are a limited number of case reports published describing the anaesthetic management of patients with HD.