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.

**B250 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 procedures is associated with many complications.

Methods We report a 40 year old man who experienced PDPH after spinal anaesthesia. His symptoms recurred after conservative management 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.

**B251 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 subtenon 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 do achieve adequate positioning. With a good communication with the nursing team and the patient we were able to attain a good operation field. Even thought, 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 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.

**B253 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.
The majority describe general anaesthesia and show a high possibility of complications.\textsuperscript{2}

Reported experience with regional anaesthesia is sparse including only a few cases of successful spinal anaesthesia (SA).\textsuperscript{3}

Methods

We report the anaesthetic management of a 49-year-old patient with HD admitted for a left tibia fracture surgery using SA.

The preoperative history and physical examination showed mild dysphagia, mild rigidity and severe choreiform movements in the extremities. After routine ASA monitoring, we sedated the patient with 2mg intravenous midazolam. Choreiform movements decreased after sedation allowing the lateral decubitus position for the technique. The dural puncture was successful on the first attempt. We used a 27-gauge Quincke needle with hyperbaric bupivacaine 0.5% and sufentanil to perform SA.

Results

The lower limbs choreiform movements were completely abolished and optimal surgical conditions were provided. Mild choreiform movements in the upper limbs remained minimal throughout the 120-min duration of surgery and only an additional 2mg of midazolam was required for adequate patient sedation. The postoperative course was uneventful and the patient was discharged from the hospital on the third postoperative day.

Conclusions

SA showed to be safe and effective for HD patients in appropriate surgical procedures for as long as 2h without compromising the patient’s comfort, providing a rapid recovery and preventing the possible disadvantages of general anaesthesia.

B254

ULTRASOUND GUIDED CONTINUOUS SUPRACLAVICULAR BRACHIAL PLEXUS BLOCK USING AN INTRAVENOUS CANNULA FOR POST-TRAUMATIC FINGER REIMPLANTATION: A CASE REPORT

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Background and Aims

Continuous blockade of brachial plexus at the Supraclavicular level, for prolonged elbow and hand surgeries, is usually achieved by using catheters. But these are costly. A cost effective method would be intravenous cannulae.

Methods

A 47 year-old ASA I male patient, was scheduled for finger re-implantation for traumatic loss of middle three fingers. He had lower respiratory tract infection. Patient refused for surgery under general anesthesia. He received premedication with Midazolam 1 mg and Fentanyl 30 microgram IV. Under ultrasound guidance, continuous supraclavicular brachial plexus block was performed using an intravenous cannula since patient could not afford a catheter. After 2% lignocaine infiltration, a 16 G IV cannula needle was inserted in-plane from lateral to medial direction and advanced to pierce sheath posterior to brachial plexus. The tip was positioned at the corner pocket and, 10 ml 2% Lignocaine with adrenaline, 10 ml 0.25% Bupivacaine and 4 mg Dexamethasone was slowly injected after intermittent negative aspiration. The cannula sheath was kept in situ. Intraoperatively Dexmedetomidine infusion was started. Injection 0.25% Bupivacaine 10 ml was repeated after 4 hours and 8 hours through the cannula.

Results

Surgery lasted for 10 hours in supine position. Supraclavicular nerve block cannula was removed immediately after surgery. Postoperatively patient was on Paracetamol 1 gm IV Q8H. Patient was pain free throughout and postoperatively upto 6 hours.

Conclusions

Intravenous cannula is a cost-effective, readily available and time saving alternative to catheter. It might be considered intraoperatively for continuous supraclavicular brachial plexus block in prolonged upper limb surgeries.