Conclusions Our case illustrates neuromodulation benefits for a rare presentation of occipital neuralgia secondary to Tourette's-related dystonia. In refractory cases like our's, ONS should be considered, which is more indicated for occipital neuralgia. Occipital nerve stimulators are safer, relatively easy to place, and clinically beneficial. However, there are risks such as lead migration, which should be further studied.

B261 LAST BUT NOT LEAST: DIFFERENTIAL DIAGNOSIS OF SEIZURES AFTER SPINE SURGERY

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Background and Aims Local anesthetics (LA) are widely used for anesthetic care with different routes of administration. Maximum allowable doses of LA are not evidence-based nor consider the site or technique of administration or patient factors.
Methods Results A 71-years-old woman with 65 Kg, ASA II (arterial hypertension and dementia), was admitted for an elective spine fusion under combined anesthesia. We started with an ultrasound-guided bilateral erector spine block with 40 ml of ropivacaine 0.375%. Then, total intravenous anesthesia with propofol and remifentanil TCI was chosen with lidocaine (1mg/kg/h) and ketamine (0,2mg/kg/h) infusions. After 4 hours of uneventful surgery, the patient was extubated and transported to the post-anaesthetic care unit where she had a tonic-clonic seizure controlled with 5mg of midazolam. To exclude the possibility of LAST, despite hemodynamic stability, an intralipid bolus and infusion were initiated. Cerebral tomography was performed showing an intraparenchymal hemorrhage involving the right cerebellar parenchyma with mass effect and reduction of the IV ventriculus. The patient passed away after 10 days in the intensive care unit.
Conclusions Management of these cases needs a multidisciplinary approach. Despite its rareness, remote cerebellar hemorrhage is a possible complication of spine surgery. However, it could also be an anesthetic side effect as very high plasma concentrations of lidocaine can result in seizures and multiple interventions of local anesthetics (MILANA) increases the risk of LAST.

Reviewing the literature, there is a dearth of studies discussing MILANA toxicity, its safety and effectiveness doses, which highlights the importance of considering LAST whenever LA are used.

B262 COMBINATION OF SERRATUS ANTERIOR PLANE CATHETER FOR UNSTABLE SEVERAL RIB FRACTURES AND SUPERIOR TRUNK CATHETER OF THE BRACHIAL PLEXUS FOR BROKEN SCAPULA AND CLAVICLE

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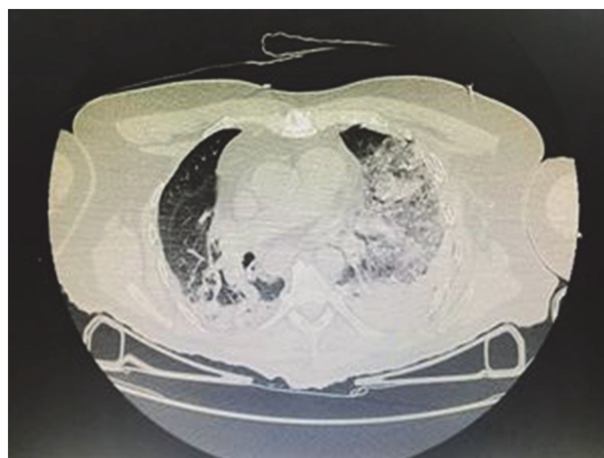
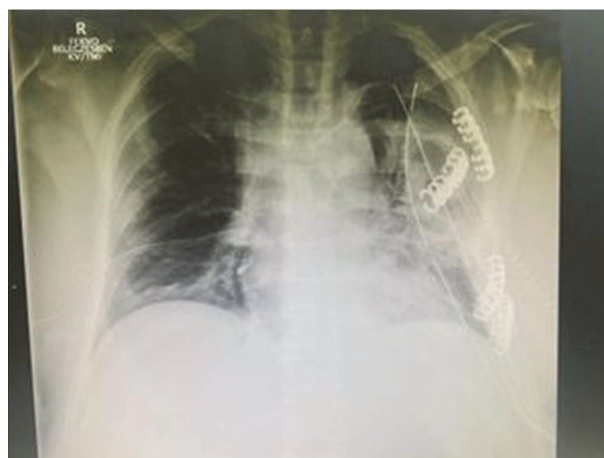
Background and Aims A 50 year-old male, ASA II has had suffered high energy blunt thoracic trauma from a road traffic accident presented with left-sided thoracic and upper limb trauma. On presentation had mild respiratory distress despite being hemaodynamically stable and an oxygen saturation of 93% on room air. Head and cervical spine were negative. Thoracic scan showed displaced rib fractures 1st to 7th and concomitant ipsilateral severe lung contusion, fractured scapula, clavicle and three thoracic vertebrae. Patient required fixation of four ribs and his elbow. Neighter the vertebrae, nor the clavicular and scapular fractures needed operative treatment.



Abstract B262 Figure 1

Methods In order to facilitate extubation and physiotherapy a superficial serratus anterior catheter were placed under ultrasound guidance and once loaded with 20 mL bupivacain 0.25% patient succesfully extubated on high-flow nasal cannula oxygen with 0/10 chestpain at rest. The severe pain around the clavicle and scapula managed effectively with a superior trunk catheter of the brachial plexus instead of interscalene to spare the phrenic nerve. Bolusing with 6 mL of Lidocain 1% provided complete analgesia with intact diaphragmatic movement on ultrasound. Continuous blocks were accomplished by intermittent boluses in every 12 hours instead of infusion in order to facilitate mobilization.



Abstract B262 Figure 2

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Results The effectivity of the intermittent blocks judged by low pain scores and superb respiratory function.
Conclusions Sublatissimus serratus catheter provied efficient pain relieve after thoracic surgery. Superior trunk catheter and low volume LA covers clavicle and scapula while preserving diaphragmatic function.

B263 NEURAXIAL ANAESTHESIA FOR OPEN CHOLECYSTECTOMY DURING A MEDICAL-HUMANITARIAN MISSION IN SUB-SAHARAN AFRICA: A CASE REPORT

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Background and Aims Open cholecystectomy is a frequently performed procedure for symptomatic cholelithiasis in Sub-Saharan Africa due to lack of laparoscopic equipment or expertise. Although it has traditionally been performed under general anaesthesia in the developed world, general anaesthesia safety and access are particularly affected by resource gaps encountered in underdeveloped countries. Therefore, neuraxial anaesthesia is increasingly considered a safe, effective, and less resource-intense option in low-resource countries.
Methods The authors describe the successful use of neuraxial anaesthesia in a 48-year-old female patient proposed for urgent open cholecystectomy during a medical-humanitarian mission at the Simão Mendes National Hospital in Guinea-Bissau. Considering the local resource gaps, namely lack of access to functioning anaesthetic machines, basic airway equipment, capnography, neuromuscular function monitors, and even oxygen cylinders, regional anaesthesia was preferred rather than general anaesthesia. After informed consent, a combined spinal-epidural anaesthesia was performed using a separate needle technique with an initial subarachnoid injection of 3 ml of 0,5% levobupivacaine and 2.5 μg of sufentanil (T12-L1 level) followed by placement of an epidural catheter (T8-T9 level) for potentially prolonged surgery and postoperative multimodal analgesia. Ketamine and midazolam were given perioperatively for analgesia and anxiolysis, respectively. The patient remained conscious, on spontaneous ventilation, without the need for supplemental oxygen therapy or vasopressors.
Results General anaesthesia was successfully avoided.

The procedure was uneventful and postoperative recovery was unremarkable, with the patient being discharged within 24 hours.
Conclusions Neuraxial anaesthesia may be a safe, effective, and less expensive approach for urgent open cholecystectomy in Sub-Saharan Africa patients under similar circumstances.

B264 DO TARLOV CYSTS USUALLY CAUSE BACK PAIN?

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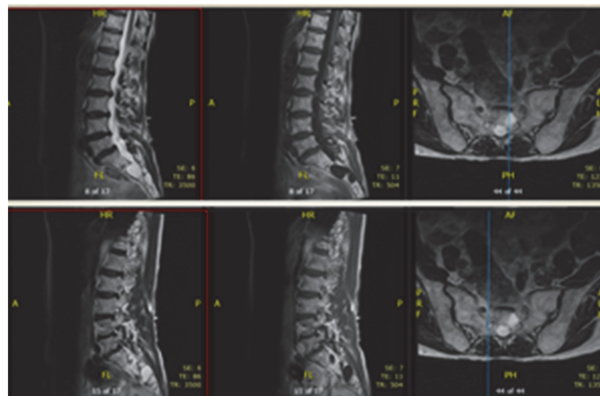
Background and Aims 61-year-old lady case of Complex Regional Pain Syndrome involving the left foot and ankle due to Left foot crush injury (3-foot fractures/first proximal phalanx and first metatarsal). Her pain has been refractory to pharmacotherapy and SCS trial then she developed new symptoms and changes in the pain character as lower back and the left buttock radiating in the outer aspect of the left posterior thigh and radiating down the calf into the outer aspect of the foot and the sole of the foot. Urgent MRI showed: Multiple prominent bilateral perineural nerve root sleeve cysts that are Tarlov cysts within the sacral spinal canal tracking along with the proximal exiting nerve roots.
Methods



Abstract B264 Figure 1

Results Tarlov cysts are an uncommon cause of back pain.Tarlov cysts are fluid-filled sacs that most often affect nerve roots at the lower end of the spine. Such cysts typically cause no symptoms and are found incidentally in magnetic resonance imaging (MRI) studies done for other reasons. (1)

Conclusions in some cases, the cysts expand, putting pressure on the affected nerve root. The results may include sharp, burning pain in the hip and down the back of the thigh, possibly with weakness and reduced sensation all along the affected leg and foot. Tarlov cysts sometimes enlarge enough to cause erosion of the surrounding bone, which is another way they may cause back pain.

In most cases, Tarlov cysts require no treatment. For those that do, some surgical treatments — such as draining the cyst, have had promising results. (1)

B265 CONTINUOUS FRACTIONAL SPINAL ANESTHESIA IN A PATIENT COMING FOR HEPATICOJEJUNOSTOMY WITH POST COVID LUNG

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Background and Aims Anesthesiologists now a days are facing a burden of anesthetising post-Covid patients with lung fibrosis, atelectasis and other respiratory complications. Regional anesthesia can be offered to such patients in the form of continuous fractional spinal anesthesia. We present our experience of managing a patient with post COVID lung posted for hepaticojejunostomy.
Methods 43 years male patient with post COVID Lung and reduced ejection fraction was posted for elective hepaticojejunostomy. He had post Covid lung fibrosis and spo2 of 94%, Functional capacity <4, sabrasez breath holding test <15 ,2D echo findings: Global hypokinesia of left ventricle with

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