

Results The effectivity of the intermittent blocks judged by low pain scores and superb respiratory function.

Conclusions Sublatissimus serratus catheter provided efficient pain relief after thoracic surgery. Superior trunk catheter and low volume LA covers clavicle and scapula while preserving diaphragmatic function.

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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-intensive 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.

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DO TARLOV CYSTS USUALLY CAUSE BACK PAIN?

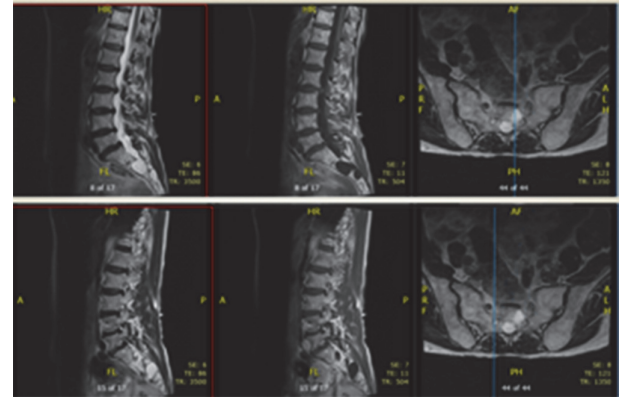
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Background and Aims 61-year-old lady case of Complex Regional Pain Syndrome involving the left foot and ankle due to Left foot crush injury (3-foot fractures/first proximal phalanx and first metatarsal). Her pain has been refractory to

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)

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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 anaesthesia can be offered to such patients in the form of continuous fractional spinal anaesthesia. 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