of aspiration (GV > 1.5 ml kg\(^{-1}\)). All these patients were fasted > 6h. 2 had a change in airway plan and 1 patient was undergoing a regional technique.

**Conclusions** Fasting > 6h does not always preclude a high risk of aspiration. POC-USG can aid decision-making as part of a multi-modal assessment of aspiration risk to improve patient safety. Ethics approval not required.

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**Central nerve blocks**

**B411** 'THE EFFECT OF DEXMEDETOMIDINE ON LIDOCAINE IN SUBARACHNOID ANAESTHESIA FOR TRANSURETHRAL SURGERY'

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**Background and Aims** Regional anaesthesia is the technique of choice in many urological surgeries, such as transurethral surgeries of the bladder (TurBT) and prostate (TurP).

**Methods** In the present randomized double blind study, 90 patients scheduled for TurP and TurBT received subarachnoid anaesthesia with either dexmedetomidine in combination with hyperbaric lidocaine 2% (3 ml) (LD-group) or hyperbaric lidocaine 2% (3 ml) (L-group) or hyperbaric ropivacaine 0.5% (3 ml) (R-group).

**Results** Patients’ demographic characteristics were similar in the 3 groups; the participants had a mean age of 70 years, with no difference among the groups (p = 0.491). BMI had a mean value to 25.9 kg/m\(^2\) with no difference among the groups (p = 0.160). Regarding intraoperative haemodynamic parameters, a statistically significant difference in blood pressure was found over time in all groups (p < 0.001). The heart rate showed a statistically significant change only in the LD-group (p = 0.002). Regarding block characteristics, the addition of dexmedetomidine was associated with a higher sensory block (T6 in the LD-group versus T10 in the L-group). Ropivacaine was also associated with high sensory block (T6) compared to lidocaine (p < 0.001). The pain assessment performed with the Numerical Rating Scale (NRS, 0–10) showed statistically significant lower values in the LD-group compared to both L-group (p < 0.001) and R-group (p < 0.001) all time periods, intra- and post-operatively.

**Conclusions** The addition of dexmedetomidine improved the quality of anaesthesia in transurethral bladder and prostate surgery compared to lidocaine alone. It provided satisfactory analgesia both intraoperatively and postoperatively, reducing opioid use, without significant haemodynamic side effects.

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**B412** NEURAXIAL USE AMONG TOTAL KNEE AND HIP ARTHROPLASTY PATIENTS WITH MULTIPLE SCLEROSIS OR MYASTHENIA GRAVIS

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**Background and Aims** Regional anesthesia use has historically been categorized as relative contraindication among patients with certain preexistent neurological disorders (1–3). It is unclear if the fear of developing new or worsening symptoms among this group is driving anesthesiologists to prefer or...
avoid a specific type of anesthesia technique. We sought to determine if neuraxial anesthesia use during TKA/THA differed among those previously diagnosed with multiple sclerosis or myasthenia gravis in comparison to the population without the diseases.

**Methods** This study is approved by Hospital for Special Surgery Institutional Review Board (IRB# 2016-436). We analyzed patients undergoing a TKA/THA procedure using the Premier Healthcare Database. We created individual multivariable logistic regression models to compare patients with multiple sclerosis or myasthenia gravis to the non-diagnosed population.

**Results** We identified 2,184,193 patients undergoing a TKA/THA procedure, with 7,559 having a preoperative diagnosis for multiple sclerosis and 3,176 for myasthenia gravis. Neuraxial use among patients with pre-existing multiple sclerosis was lower (OR: 0.62, p=<.0001) than the non-diagnosed population (Table 1). Neuraxial anesthesia use among patients with pre-existing myasthenia gravis was not significantly different than use among the non-diagnosed population (OR: 1.05, p=0.2359).

**Conclusions** Neuraxial anesthesia use during a TKA/THA procedure among those with pre-existing multiple sclerosis was significantly lower than those without the disease while about the same as controls for myasthenia gravis, respectively. Although previous research indicates that there is no relationship between neuraxial use and the exacerbation of symptoms in those with multiple sclerosis, there is indication that anesthesiologists are more likely to use general anesthesia.

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**TREATING SPONTANEOUS INTRACRANIAL HYPOTENSION WITH AN ANESTHETIC MODALITY: THE ROLE OF THE EPIDURAL BLOOD PATCH**

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**Background and Aims** Spontaneous intracranial hypotension (SIH) is a rare syndrome characterized by heterogeneity of presentation and prognosis, which can occasionally result in serious complications. This case series aims to emphasize that SIH remains a diagnostic and therapeutic challenge; if conservative treatment fails, an epidural blood patch (EBP) is a viable treatment option. Although the exact aetiology of SIH is not known, it is believed to be due to cerebrospinal fluid (CBF) leak or a low CBF pressure.

**Methods** Three patients with age ranging between 38–53 years old who presented with complaints not only of an orthostatic headache, but with a variety of symptoms of SIH, including the formation of two subdural hematomas in one of them, were included in this series. These patients did not respond to conservative management and subsequently were referred to the Anaesthesia Department for an EBP.

**Results** All three patients were subjected to an EBP with an 18-gauge epidural needle placed into the middle epidural compartment at the T12–L3 level. A total of between 30–43 ml of autologous blood was collected from the patients’ left basilic vein and was injected into the epidural space under strict aseptic conditions. All patients reported complete resolution of symptoms following the EBPs, while magnetic resonance imaging improved substantially.