

Abstract B415 Table 2

Table 2: Comparison according to type of anaesthesia in the COVID-19 pandemic

Parameter	General anaesthesia (n=84)	Regional anaesthesia (n=74)	P value
Age, years, median [min-max]	54 [18-87]	47,50 [21-80]	0.041
Gender, male, n (%)	63 (75%)	62 (83,8%)	0.175
BMI (kg/m ²), median [min-max]	29,70 [23,44-36,41]	24,76 [20,99-38,97]	0.011
ASA physical status class, n (%)			0.016
ASA 1	14 (16,7%)	22 (29,7%)	
ASA 2	49 (58,3%)	46 (62,2%)	
ASA 3	18 (21,4%)	6 (8,1%)	
ASA 4	3 (3,6%)	0 (0,0%)	
Type of surgery, n (%)			0.168
Lower abdominal (inguinal hernia)	35 (41,7%)	23 (31,1%)	
Perianal surgery (abscess, fistula, and hemorrhoidectomy)	49 (58,3%)	51 (68,9%)	
Emergency, n (%)	57 (67,9%)	32 (43,2%)	0.002
Duration of operation, minutes, median [min-max]	32,50 [10-190]	30 [10-210]	0.259
Patients with ICU need, n (%)	23 (27,4%)	0 (0,0%)	<0.001
Length of hospital stay, days, median [min-max]	1 [0-32]	1 [0-12]	<0.001
Rehospitalisation, n (%)	5 (6,0%)	4 (5,4%)	1.000*
Any kind of postoperative complication, n (%)	16 (19,0%)	6 (8,1%)	0.047
Postoperative cardiovascular complications, n (%)	7 (8,3%)	1 (1,4%)	0.068*
Postoperative pulmonary complications, n (%)	8 (9,5%)	2 (2,7%)	0.105*
Mortality, n (%)	1 (1,2%)	1 (1,4%)	1.000*

BMI: body mass index, ICU: intensive care unit

*Fisher's exact test

Conclusions We noticed an increase in performing regional anaesthesia after the pandemic in our institute. Although we observed more complications in the pandemic than in 2019; postoperative complications, including pulmonary were lower in patients had regional anaesthesia.

B416

TWO-YEAR ANALYSIS OF CONTINUOUS SPINAL ANAESTHESIA: A SAFE AND "GO WITH THE FLOW" TECHNIQUE IN HIGH-RISK PATIENTS

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Background and Aims There is a growing number of elderly patients with severe comorbidities requiring surgery. Continuous spinal anaesthesia (CSA) is an old technique that allows titration of local anesthetic (LA).

Methods Data from CSA in 2020–2021 was retrospectively reviewed. A total of 34 patients received CSA using a standard 18-G epidural catheter, removed at the end of surgery. Statistical analysis was performed using IBM SPSS® Statistics, 26. The study was approved by local institutional ethics committee.

Results Out of 34 patients, 53% were females. Median patient's age was 87 ± 6 . Cardiovascular disease was the most common comorbidity (Table 1). The most common procedure was orthopaedic hip surgery (Table 2). Median surgery duration was 80 ± 41 min. Total dose of LA ranged between 1,9 and 8,0 mg ($5,5 \pm 1,5$) and intrathecal opioid was used in 62% (fentanyl 10–25 µg or sufentanil 1,5–2 µg) - Table 3. Hypotension was the most common complication (38%). No major intraoperative complications were observed. There were no reports of postdural puncture headache, neurological deficits, or infection during hospitalization.

Abstract B416 Table 1

Table 1 - Patient's Baseline Characteristics n = 34

	Female	Male
Sex - n (%)	18 (53)	16 (47)
Age - median (IQR)	87 (6)	
ASA - n (%)		
	III	23 (68)
	IV	11 (32)
Hypertension - n (%)	Yes	24 (71)
	No	10 (29)
Congestive Heart Failure - n (%)	Yes	14 (59)
	No	20 (41)
Severe aortic stenosis - n (%)	Yes	9 (27)
	No	25 (73)
Atrial Fibrillation/Flutter - n (%)	Yes	14 (41)
	No	20 (59)
Diabetes - n (%)	Yes	9 (27)
	No	25 (73)
Respiratory Disease - n (%)	Yes	7 (21)
	No	27 (79)
Anemia - n (%)	Yes	8 (24)
	No	26 (76)

IQR - Interquartile Range

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Table 2 - Type of Surgery

Orthopedic hip surgery - n (%)	24 (71)
Colostomy - n (%)	3 (9)
Inguinal hernia repair - n (%)	1 (3)
Segmentar enterectomy - n (%)	2 (6)
Lower limb amputation - n (%)	3 (9)
TURP - n (%)	1 (3)

TURP - transurethral resection of the prostate

Abstract B416 Table 3

Table 3 - LA, opioid and vasopressores consumption

Bupivacaine (mg) - Mean (SD)	5,5 (1,5)
Opioid - n (%)	21 (62)
Ephedrine (mg) - Median (IQR)	27,5 (16)
Phenylephrine (µg) - Median (IQR)	350 (250)

IQR - Interquartile Range; SD - Standard Deviation

Conclusions CSA remains a reliable and safe anaesthetic technique, particularly in very frail patients with cardiac diseases. It allows the use of fractionated doses of LA until the desired surgical sensory blockade is achieved, minimizing the risk of severe hypotension. Additionally, with an intrathecal catheter in place, it is possible to extend the anaesthesia duration as needed. Thus, CSA still have a place in modern anaesthesia, particularly in high-risk patients proposed to long-lasting surgeries.

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CONTINUOUS SPINAL ANAESTHESIA USING WILEY SPINAL FOR MAJOR ABDOMINAL SURGERY – A RETROSPECTIVE STUDY BETWEEN 2017 AND 2021

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Background and Aims Recurrent cancer and metastases depend on the perioperative immune competence which is impaired by Surgery , Anaesthesia and Opiates

CSA attenuates the surgical stress response and decreases anaesthetic requirements affording rapid rehabilitation and good early and late outcome

Methods 78 ASA I-III patients age ranged from 38 to 84 underwent awake open or laparoscopic abdominal surgery for cancer : gastrectomy , colectomy, radical prostatectomy , cysto-prostatectomy , hysterectomy under CSA

Puncture between L2-L3 in the lateral decubitus ; a 23G spinal catheter over a 27G Whitacre needle (Wiley Spinal) was introduced 3 cm intratechally

First dose 20 mg plane Bupivacaine + 10 µg Sufentanyl + 4 mg Dexamethasone in a total volume of 5 ml

Complementary boluses of 10 mg Bupivacaine were required every 90 mins

Patient controlled spinal analgesia 48 to 72 hours : Top ups on demand Bupivacaine 1,25 mg + 0,1 mg Morphine in 3 ml volume every 12 hours

Results Mean duration of surgery 180 mins with perfect hemodynamic stability and surgical comfort

Maximum consumption of LA and opiates in the first post-operative 36 hours : 3,75 mg Bupivacaine and 0,3 mg Morphine

Postoperative ileus maximum 24 h

PDPH 0 Pruritus 10%

Nausea 20%

Conclusions Major abdominal surgery under CSA is technically feasible , safe and efficient avoiding GA and the use of curares , opiates and Noradrenaline .

It makes possible early mobilisation , active nursing , earlier nutrition and decreases respiratory morbidity rate .

Excellent immediate and late outcome with high patients satisfaction

Significant cost -effectiveness

B418 MASTECTOMY UNDER THORACIC EPIDURAL: YES WE CAN!

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Background and Aims Mastectomy is frequently performed under general anaesthesia (GA)¹. Occasionally, regional anaesthesia has been described as the sole anaesthetic technique. We aim to present a female with congenital muscular dystrophy (CMD) undergoing modified radical mastectomy (MRM) and axillary dissection (AD) with an anaesthetic thoracic epidural.

Methods A 75-year-old female with a history of CMD and flaccid tetraparesis with severe respiratory involvement was scheduled for MRM with AD due to cancer. An epidural catheter was inserted 5cm cephalad in the T4/T5 interspace. A test dose was administered followed by a 7 mL bolus of 0.5% ropivacaine and 1mg morphine. BIS-guided sedation with propofol target-controlled infusion was performed. Surgery was uneventful. She was transferred to the PACU for monitoring and was discharged without complications.

Results Patients with CMD represent high-risk surgical candidates. Rhabdomyolysis and respiratory failure are concerns

with GA². Anaesthesia of the breast is possible with nerve blocks and thoracic epidural¹. Due to its complex innervation, multiple blocks must be combined to achieve complete anaesthesia of the breast³. Additionally, sonoanatomy may be altered in CMD, increasing technique difficulty and failure rates⁴. Thoracic epidural was performed due to our superior experience. Advantages include surgical stress attenuation, postoperative analgesia and prompt recovery¹. The catheter would also allow local anesthetic top-ups.

Conclusions Although CMD is challenging, alternatives to GA are possible for mastectomy. Thoracic epidural allows maintenance of spontaneous ventilation, provides adequate surgical anaesthesia and postoperative analgesia, representing a suitable option for patients with myopathy presenting for mastectomy.

B419 PATIENT OUTCOMES FOLLOWING HIP FRACTURE SURGERY USING INTRATHECAL 2% PRILOCAINE ALONGSIDE PERIPHERAL NERVE BLOCKS

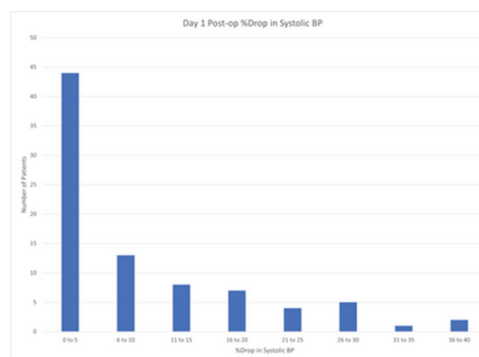
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Background and Aims Regional anaesthesia has increasingly become the mode of anaesthesia for hip fractures in view of the frail, elderly multiple comorbid populations who usually succumb to this significant injury. Bupivacaine is often the choice for spinal anaesthesia however, local anaesthetics like 2% Prilocaine (Prilotekal[®]) are gaining popularity in recent years due to their fast offset and better side effects profile. We analysed patient outcomes using intrathecal Prilocaine alongside peripheral nerve blocks and Eleveld modelled target-controlled infusion (TCI) 1% Propofol for sedation. Ethical committee approval was deemed unnecessary by our audit and research department as patients receive short-acting spinal anaesthesia with blocks routinely.

Methods Data from 84 patients who received intrathecal 2% Prilocaine alongside ultrasound-guided peripheral nerve blocks (Femoral and Lateral cutaneous nerve of thigh) and Eleveld TCI Propofol sedation were analysed. We recorded the day 1 post-op systolic blood pressure, pre and post-operative pain score, length of stay and 30-day mortality.

Results We noted that no patient required additional analgesia in recovery, no admissions to intensive care and 30-day mortality was found to be 4%, which is better than the UK national average. The mean length of stay in the hospital was found to be 18 days.



Abstract B419 Figure 1 Day 1 Postoperative % Drop in Systolic BP