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.

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 ± 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.

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.
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 aged 38 to 84 years 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 postoperative 36 hours: 3,75 mg Bupivacaine and 0,3 mg Morphine.

Postoperative ileus maximum 24 h.

PDFH 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.

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

Background and Aims. Mastectomy is frequently performed under general anaesthesia (GA). 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 5 cm cephalad in the T4/T5 interspace. A test dose was administered followed by a 7 mL bolus of 0.5% ropivacaine and 1 mg 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 epidural. Due to its complex innervation, multiple blocks must be combined to achieve complete anaesthesia of the breast. Additionally, sonoanatomy may be altered in CMD, increasing technique difficulty and failure rates. Thoracic epidural was performed due to our superior experience. Advantages include surgical stress attenuation, postoperative analgesia and prompt recovery. 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.

Abstract B418 Mastectomy Under Thoracic Epidural: Yes We Can!


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