**Abstracts**

**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, cystoprostatectomy, 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 Morphin in 3 ml volume every 12 hours.

**Results** Mean duration of surgery 180 mins with perfect hemodynamic stability and surgical confort.

Maximum consumption of LA and opiates in the first postoperative 36 hours: 3,75 mg Bupivacaine and 0,3 mg Morphin.

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). 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 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 rate. 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.

**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 modelled target-controlled infusion (TCI) 1% Propofol for sedation. We recorded the day 1 post-op systolic blood pressure, pre and post-operative pain scores, 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.