Continuous fractional spinal anesthesia offers the advantage of fractionating the doses of local anesthetic in the subarachnoid space and has lesser effect on respiratory and cardiac physiology.

Conclusions Continuous spinal anesthesia (CSA) is a safer alternative technique to general anesthesia in patients with severe cardio-respiratory disease in whom general anesthesia could result in prolonged ICU stay.

NEURAXIAL ANAESTHESIA FOR ACUTE ABDOMEN
SURGERY IN A MEDICAL-HUMANITARIAN MISSION IN
SUB-SAHARAN AFRICA

Background and Aims Acute abdomen is an emergency requiring immediate surgical intervention, for which midline exploratory laparotomy is the most commonly performed procedure. Although traditionally performed under general anesthesia in the developed world, general anesthesia can be challenging in Sub-Saharan Africa due to resource gaps. Therefore, in under-developed countries the anesthetic approach must be frequently adjusted, with regional anesthesia growing in relevance.

Methods The authors describe the successful use of neuraxial anesthesia in a 38-year-old female patient with acute abdomen proposed for emergent midline exploratory laparotomy during a medical-humanitarian mission at the Simão Mendes National Hospital in Guinea-Bissau. Considering the scarcity of resources, namely lack of access to functioning anesthetic machines, basic airway equipment, capnography, and even oxygen cylinders, regional anesthesia was preferred rather than general anesthesia. After informed consent, a combined spinal-epidural anesthesia was performed using a separate needle technique with an initial subarachnoid injection of 2.5 ml of 0.5% bupivacaine and 2.5 μg of sufentanil (L1-L2 level) followed by placement of an epidural catheter (T8-T9 level) for potentially prolonged surgery and postoperative multimodal analgesia. Despite airway security and pulmonary aspiration concerns, the patient remained conscious, on spontaneous ventilation.

Results General anesthesia was successfully avoided and there was no need for supplemental oxygen therapy or vasopressors, although episodes of vomiting did occur. Intestinal perforation was diagnosed intraoperatively and small bowel resection and anastomosis were performed uneventfully. Postoperative recovery was unremarkable.

Conclusions Neuraxial anesthesia may be a safe, effective, and less expensive approach for acute abdomen surgery in Sub-Saharan Africa patients under similar circumstances.
Background and Aims The primary aim was to access postoperative mobility, secondarily to measure the length of hospital stay, pain score, opioid consumption, and side effects.

Methods After ethical committee approval, a retrospective study was conducted with 50 patients who underwent primary THA. Twenty-eight patients received PENG block after spinal anaesthesia (SA) (Group-PENG), 7 patients had general anaesthesia with PCA postoperatively (Group-PCA), and the remaining 15 received SA with fascia-iliaca block (Group-FIB). The mobilisation was attempted in all patients (ability to stand and walk a few steps with a walker) after 10 hours of surgery. Data was collected for average postoperative pain score, time of mobilisation, total opioid consumption, opioid-related side effects, and discharge time from the hospital.

Results In the Group-PENG, 26 patients (n=28) were mobilised within the first 10 hours without any opioids. All other patients received average 9 ± 2.1 mg morphine before mobilisation. The average time of discharge (hours) from the hospital (22.1±4.9) was also significantly lower in Group-PENG compared to all others (31.7 ± 3.4, p=<0.01). Average postoperative pain score was significantly low in Group-PENG within the first 48 hours. Opioid-related complications were least in Group-PENG.

Conclusions The PENG block helps in early mobilisation and enhanced recovery after THA. It provides adequate analgesia for early mobilization and is easy to perform in the supine position after spinal analgesia.


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Background and Aims Internationally obstetric anesthesia guidelines recommend regional over GA for most cesarean deliveries. Continuous caudal anesthesia in obstetric anesthesia was first reported in 1943, after which lumbar access to the peridural space became widely used. We report the anesthetic management of a parturient with a difficult spine in whom we were able to place a US guided continuous caudal catheter and provide adequate anesthesia for the surgery.

Methods A 25yr old primigravida with 38 weeks gestation, short stature (121.8 cms) with a thoracic gibbus and difficult airway was posted for cesarean section. MRI of the spine could not be done due to financial constraints. Preprocedural scanning of the neuraxis done in view of altered spine anatomy. Spinal anesthesia could not be achieved despite multiple attempts due, since neuraxial scan revealed a good view of caudal space, a continuous caudal catheter was placed under ultrasound guidance using an 18G Tuohy needle.