16 ml 2% lignocaine with adrenaline. Surgery uneventful with minimal hemodynamic perturbations. Time taken for 2 segment regression of sensory block in this case was around 245 minutes.

Conclusions A continuous caudal catheter placed under ultrasound guidance can be considered as a safe modality for providing anesthesia/analgesia in parturients with a difficult spine anatomy.

Background and Aims Regional blocks as sole anaesthetic techniques are gaining importance, particularly in patients with extensive comorbidities, where general anaesthesia is high risk. Blocks for surgeries involving neck are more challenging and carry high risk due to the presence of vital structures around. This report describes anaesthetic management of awake parathyroidectomy with bilateral cervical plexus block in a high risk patient.

Methods 81 years male with history of CAD for 20 years, past MI, CABG with 3 grafts, chronic heart failure, poor functional capacity, NYHA class III, uncontrolled hypertension, TIA thrice in the past, hypercholesterolemia, fatty liver with deranged liver functions and stage 3 CKD, has been posted for elective parathyroidectomy for refractory hypercalcemia. He was evaluated in preoperative clinic, options of anaesthetics discussed and decided for regional technique. On the day of surgery, he was made to lie down with 30° head-up tilt, standard AAGBI monitors connected, iv cannula inserted, aseptic precautions undertaken, neck ultrasound performed, ‘Stop before the block’ adhered to; Left superficial cervical plexus block performed with 50ml NRfit needle viewing needle in-plane with ultrasound using 10ml 0.5% levobupivacaine. The same procedure is repeated on right side.

Results After 15 minutes waiting time, block assessed at surgical site with pin-prick. After ensuring that block quality is good, he was started on conscious, arousable sedation with propofol TCI. Procedure lasted for 80 minutes and the patient was comfortable and pain free. Peri-operative period was uneventful. Time taken for 2 segment regression of sensory block in this case was around 245 minutes.

Conclusions Bilateral cervical plexus blocks can be used as sole anaesthetic technique in experienced hands for selected patients, particularly high risk ones.

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Background and Aims Post dural puncture headache is relatively common in obstetric patients who have received central neuraxial anaesthesia. Symptoms of PDPH are often severe, debilitating and potentially long lasting. Treatment options for PDPH are limited and the only treatment which has been shown to be effective is an epidural blood patch. EBPs carry risks in itself and the decision to perform this is not taken lightly. Performing an EBP requires appropriate assessment of the patient, consenting of the procedure and follow up among other recommendations.

Methods We anonymously retrospectively looked collected data regarding all epidural blood patches performed in a single centre over a 4 year period. Details of the dural puncture, onset of symptoms, consent, documentation of risks, procedure details and follow up were all recorded. We have compared this to the OAA recommendations.

Results 23 blood patches in 20 patients, 8 patients had only spinal, 2 had an epidural followed by spinal while 10 had only epidural procedure. Headache developed within 48 hours in 17 cases, Blood patch was performed between day 2 and day 6 in 18 patients. There is one patient that had blood patch day 10 and 13 with complete resolution of symptoms day 14 from initial epidural, and another patient that had blood patches day 3 and 23 post initial spinal, in the epidural group 8 were recognised as dural taps on insertion.

Conclusions We have practice according to OAA recommendations, they were adequately consented and they were given 48 hours of conservative treatment and they were followed up adequately.