

Conclusions ESPB may reduce opioid consumption, extubation time, ICU and hospital stay after OPCAB. It effectively reduces pain at 6 and 12 hours post- extubation, but not at 24 hours, probably due to its duration. Larger studies are needed for comprehensive conclusions.

Central nerve blocks

#35700 USE OF INTRALIPID FOR THE REVERSAL OF LOCAL ANAESTHETIC BLOCKADE FOLLOWING NEURAXIAL ANAESTHESIA – A CASE SERIES

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Background and Aims Neuraxial anaesthesia for caesarean section (CS) with local anaesthetics is frequently performed, however these procedures can cause high-level blockade or Local Anaesthetic Systemic Toxicity (LAST). Evidence supporting the use of intralipid as a reversal agent following high-spinals is scarce.

Methods This case series presents the reversal of two patients with high spinal blocks with intralipid emulsion. Written consent was obtained.

Results Case 1: A 27-year-old primigravid at 40 weeks 3 days of gestation was referred for a CS following foetal distress and slow labour progression. 2% lignocaine was given epidurally in 5ml aliquots (Total 20ml over 45 minutes). Postoperatively, the patient had increased work of breathing, hypotension, and bilateral upper arm weakness. This persisted for 50 minutes with block to ice at C2 bilaterally. Intralipid emulsion was given in 5-10ml aliquots (Total 50ml). Rapid block recession to T4 bilaterally within 15mins. Case 2: A 26-year-old primigravid at 38 weeks and 2 days gestation was referred for a CS due to obstructed labour. An epidural performed earlier only provided a unilateral block. A spinal neuraxial was performed. Block to ice was noted at C7 after delivery, with hypotension and increased work of breathing. 20ml of Intralipid was given, with block recession to T1. A second 20ml intralipid bolus was given and the block recessed to T4.

Conclusions Early intralipid administration rapidly reverse neuraxial anaesthesia and prevent LAST. This study supports the safe use of intralipid. Future research is required to investigate the appropriate timing and dosing of intralipid when used in such circumstances.

#36336 INTRODUCING AN AMBULATORY SPINAL SERVICE FOR ORTHOPAEDIC SURGERY AT A DISTRICT GENERAL HOSPITAL

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Background and Aims Short-acting intrathecal local anaesthetics, such as prilocaïne, have advantages for ambulatory day-case surgery due to rapid onset and offset of anaesthesia, rapid recovery of protective reflexes, mobility and micturition. Intrathecal prilocaïne for day-case unicompartamental knee replacement (UKR) has been introduced at an orthopaedic hospital in the UK. The study aims are: 1. To assess feasibility of an ambulatory spinal service for elective UKR 2. To introduce prilocaïne for day-case UKR

Methods Stage 1 was a retrospective review of 29 UKRs in 2020 recording time from anaesthesia to surgery end to demonstrate feasibility of prilocaïne use. Stage 2 recommended using heavy prilocaïne 20% with fentanyl. Data collected for UKR cases between Jan – May 2023 included anaesthetic dose, time from anaesthesia to surgery end, post-operative pain scores, analgesic requirements, length of stay and patient satisfaction.

Results Stage 1 found that mean procedure time was 72mins. Stage 2 found that 80% were discharged within 24h, 0% had urinary retention, pain scores were between 2-10/10, they all required oral opiate analgesia, time to mobilisation was poorly documented, patient satisfaction was between 4 and 5 out of 5.

Conclusions UKR can successfully be achieved as a day-case procedure with intrathecal prilocaïne. To facilitate this patients should be first on the theatre list and receive pre-operative education regarding physiotherapy and post-operative analgesic requirements. Good analgesia is required with regular paracetamol, NSAIDs if not contraindicated and opiates. A guideline for all multidisciplinary teams, including physiotherapy, pharmacy and the ward nurses will further support same day discharge.

Attachment Ethics approval not required.pdf

#36197 REGIONAL ANAESTHESIA FOR LAPAROSCOPIC SURGERY

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Background and Aims Laparoscopy is a procedure requiring total muscular relaxation, traditionally performed under GA. Regional anaesthesia provides total analgesia and muscle relaxation with complete preservation of consciousness and rapid postoperative recovery. Spinal and combined spinal-epidural blocks have been used for laparoscopic general surgery in patients with relevant medical pathologies including coexisting pulmonary disease. This study shows the feasibility of all types of laparoscopic surgery under CSE, on awake patients.

Methods 655 ASA I to III patients between 30 and 80 years old scheduled for different laparoscopic surgery (cholecystectomy, appendectomy, colectomy, sigmoidectomy, inguinal hernia, prostatectomy and hysterectomy) were included in this protocol after informed consent. After monitoring preloading and light sedation, with the patient in left lateral decubitus epidural space was identified by the loss of resistance to air technique between L1-L2. A 27G spinal needle was

introduced in the subarachnoid space and 20 mg Bupivacaine + 7,5 µg Sufentanil + 4 mg Dexamethasone in a total volume of 5 ml were injected. Patients were placed in the Trendelenburg position until sensitif block level at T2. Maximum intraperitoneal pressure didn't exceed 12 mm Hg.

Results 70 patients (10,68%) experienced shoulder pain after pneumoperitoneum successfully treated with 0,5 mg iv alfentanil. 1 patient required conversion to GA. Duration of procedures ranged between 25 and 180 mins.

Conclusions RA affords excellent muscle relaxation, total per and postoperative pain relief, rapid discharge. Different studies showed a better outcome in frail and obese patients compared to GA.

#34814 SEGMENTAL THORACIC SPINAL ANAESTHESIA FOR BREAST CANCER SURGERY: A FEASIBILITY STUDY

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Background and Aims Literature on thoracic spinal anaesthesia (TSA) for breast surgery is scarce. The present series explored block characteristics and outcomes in the patient undergoing Modified Radical Mastectomy (MRM) under TSA in female patients with ASA I-III physical status.

Methods 20 patients underwent unilateral MRM. TSA was given with 0.75% isobaric ropivacaine (1ml), fentanyl (25 µg) and dexmedetomidine (10 µg) at T4- T5 space. All patients received IM glycopyrrolate and IV ondansetron pre-operatively, pre-loaded with IV RL @10ml/kg. fentanyl sedation @1mcg/kg IV in divided doses. Intra-operative hemodynamics, block characteristics, intraoperative complications, pain score and analgesic consumption, postoperative adverse effects, and patient satisfaction with were studied.

Results TSA was performed easily in all the patients, including two patients who complained of paraesthesia. The TSA was effective for surgery in all 19 patients. 4 patients had intraoperative apnoea with only one patient requiring bag and mask ventilation but none requiring conversion to general anaesthesia. 6 patients required mephentermine more than the median dose i.e. 12mg IV. One patient had hypotension with tachycardia and 2 patients had intraoperative bradycardia none required IV atropine. Recovery was uneventful, only 3 patients had complaints of PONV and only 2 patients required IV tramadol (50mg). 16 patients were satisfied with the anaesthesia technique and 3 patients were dissatisfied.

Conclusions This feasibility study has shown that TSA can be used successfully and effectively for MRM surgery. However, the use of anaesthetic techniques requires experience and great caution.

#36280 NEURAXIAL ANAESTHESIA IN A PATIENT WITH COFFIN-SIRIS SYNDROME – A CASE REPORT

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Background and Aims Coffin-Siris syndrome (CSS) is a rare genetic disorder, with less than 250 molecularly confirmed cases worldwide. It is characterized by growth restriction, developmental delay, craniofacial malformations, and a range of heart, gastrointestinal, genitourinary and nervous system abnormalities. These abnormalities may present an anaesthetic challenge mainly due to difficult airway management, respiratory complications and poor patient cooperation. The available literature on CSS anaesthetic approach consists of 10 case reports, with only one describing a regional anaesthesia technique.

Methods A 14-year-old female patient with CSS was scheduled for bilateral proximal tibial hemiepiphysiodesis. Preoperative evaluation was significant for developmental delay, obstructive sleep apnoea, IgA deficiency with several respiratory infections over the last year and hypertrophic cardiomyopathy. A history of doubtful delayed emergence from general anaesthesia, despite recovery of spontaneous ventilation, was present in past procedures. Physical examination revealed obesity, a short neck and macroglossia. A deep sedation was accomplished intravenously with propofol and fentanyl, and maintained with sevoflurane 1,5%, ensuring spontaneous ventilation through a laryngeal mask airway. An L3-L4 epidural block was performed with ropivacaine 0,5%. ASA standard monitoring and bispectral index were applied, and multimodal analgesia was ensured.

Results Hemiepiphysiodesis was successfully performed under the proposed anaesthetic technique, combining neuraxial anaesthesia and sedation. The perioperative period was uneventful.

Conclusions CSS patients can be challenging for the anaesthesiologist due to the syndrome's malformation spectrum, cardiac structural disease, respiratory complications and lack of reassuring literature. Neuraxial anaesthesia may be a successful and safe approach for CSS patients in selected procedures.

#36221 THE EPIDURAL DEXMETOMIDINE REDUCES THE DOSE OF ANESTHETICS DURING GENERAL ANESTHESIA

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