#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, 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 intra-operative 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 hemiepiphyseodesis. 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 macrogllossia. 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 Hemiepiphyseodesis 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 DEXMEDETOMIDINE REDUCES THE DOSE OF ANESTHETICS DURING GENERAL ANAESTHESIA

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Background and Aims: Dexmedetomidine is a centrally acting alpha-2 receptor agonist has different beneficial effects when administered epidurally. This randomized controlled study was designed to demonstrate that epidural dexmedetomidine decrease total dose anesthetics during general anesthesia.

Methods: 45 patients undergoing general anesthesia for elective colon resection due to cancer were randomly allocated into two groups. Gr.1 had 1 μg·kg⁻¹·h⁻¹ dexmedetomidine epidural with ropivacaine 30 mg 25 minutes before induction to general anesthesia and Gr.2 was given fentanyl 100 μg with ropivacaine 30 mg. The depth of anesthesia was guided by BIS with target level between 40 and 60. The consumption of propofol, i.e. fentanyl and muscle relaxants were measured.

Results: 22 patients with dexmedetomidine and 23 with fentanyl were enrolled in the study. Patients did not differ by age, p=0.7471. Duration of anesthesia in Gr.1 was 171.7±38 min, and the Gr.2 155.7±45.4, (p=0.4902). The dose of Atracurium was lower in Gr.1 (1,05±0,3 mg/kg) then Gr.2 (1,18±0,4 mg/kg), p=0.6796. Duration of awakening in Gr.1 was longer (16,4±8,2 min) than in Gr.2 (10,7±2,6 min), p=0.0555. BIS values in Gr.1 in the was 41,1±11, and in the Gr.2 45,2±10, p=0.0004. The total dose of propofol was lower in Gr.1 (1,28±0.2 mg/kg) than in Gr.2, (1,77±0.7 mg/kg), p=0.0108. The total dose of fentanyl was less in Gr.1 (5,46±4,4 μg/kg) than in Gr.2 (8,73±3,8 μg/kg), p=0.0171.

Conclusions: epidural dexmedetomidine decreases the doses of propofol and fentanyl during general anesthesia, but increases the duration of awakening time without increasing doses of muscle relaxants.

#34048 THE OPTIMAL ANESTHETIC TECHNIQUE FOR HYSTERECTOMY ON A PATIENT WITH PROGRESSIVE EXTERNAL OPHTHALMOPLEGIA WITH MYOPATHY AND ITS IMPACT ON THE MODE OF SURGERY

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Background and Aims: The mitochondrial disease (chronic progressive external ophthalmoplegia with myopathy) poses many challenges to the anesthesiologists as eyelid ptosis can be isolated or associated with laryngeal and respiratory muscles affections.

Methods: We present a case a 47-year-old female with CPEO with myopathy evaluated in anesthesia clinic for laparoscopic subtotal hysterectomy, she had in addition to eyelid ptosis, difficulty swallowing and choking with liquids, nasal speech and weakness in her arms and pain cramps in her legs. She is also diabetic and hypertensive. Neurological consultation was done with recommendations to avoid paralytic agents and certain mitochondrial metabolized medications. Cardiac and IM consultation was carried out. The impact of her condition on anesthetic approach was discussed with the gynecologist and regional anesthesia was strongly recommended over general Anesthesia. Hence the patient was counseled, and the procedure was changed to laparotomy under CSE. The full anesthetic techniques were fully explained to the patient.

Results: The intra-operative and postoperative remained uneventful and the patient shifted to PACU pain free.

Conclusions: CPEO with myopathy present limitations to anesthesiists. Choosing regional anesthesia with sedation gave a wide range of safety and made the challenging cases easier. Close communication and collaboration between the surgeon and anesthesiologist are essential to ensure the safe and optimal management of such cases.

#35837 FAILED SPINAL COMPONENT DURING NEEDLE-THROUGH-NEEDLE COMBINED SPINAL-EPIDURAL ANAESTHESIA: TOTAL HIP AND KNEE ARTHROPLASTY DONE UNDER EPIDURAL ANAESTHESIA

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Background and Aims: Combined spinal-epidural (CSE) is a neuraxial technique where injection of local anaesthetic into the subarachnoid space and placement of an epidural catheter is performed in the same procedure.

Methods: Case 1 is a 69-year-old female who underwent total knee arthroplasty. CSE was performed using a needle-through-needle technique with the B.Braun Espocan®. A 18G Tuohy needle was inserted at L3/L4 in the midline in sitting position and advanced until loss of resistance to saline obtained. 27G spinal needle was inserted through Tuohy needle up to the maximal protrusion length, however no CSF was obtained. Epidural catheter was inserted and epidural anesthesia initiated with 15mls 0.5% bupivacaine. Case 2 is a 63-year-old male who underwent total hip arthroplasty, CSE was performed with the same technique. Intrathecal component was not given as CSF was not flowing freely. Epidural catheter was inserted and epidural anaesthesia initiated with 18mls 0.5% bupivacaine.

Abstract #35837 Table 1 Causes of failed spinal component in CSE

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<td>Spinal needle exits Tuohy needle which lack the tool to back hole</td>
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Results: Both patients underwent total knee and hip arthroplasty uneventfully under epidural anaesthesia in an operative time of 4 and 5 hours respectively.