



Abstract #35790 Figure 3 Postoperatively, patient is awake, comfortable, with Bromage 0

Results After confirming the desired block height of T2, surgery was started. The procedure commenced without any complications. Patient remained comfortable, easily arousable, and responsive during the whole operation and did not require additional sedation intraoperatively. The procedure lasted 2 hours and 9 minutes, with no complaints of poor muscle relaxation from the surgical team. Post-operatively, the patient's vital signs were well within normal range, and she had no subjective complaints. The patient is also Bromage 0 immediately after the surgery and has no motor or sensory deficits.

Conclusions Segmental thoracic spinal anesthesia may be a viable option for regional anesthesia in laparoscopic cholecystectomy. It provides effective pain relief, reduces opioid use, and minimizes side effects.

#34414 LAPAROSCOPIC TOTAL EXTRAPERITONEAL INGUINAL HERNIA REPAIR UNDER SPINAL ANESTHESIA: CASE REPORT

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Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

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Background and Aims Inguinal hernia repair is one of the most commonly performed elective surgical procedures. Total extraperitoneal (TEP) which is the most preferred one among laparoscopic methods, is usually performed under general anesthesia (GA). However, there are reports showing TEP has been performed under regional anesthesia. We would like to share our experience on this matter.

Methods A 40 year-old male patient presented to general surgery service with pain and swelling in the right inguinal region and was scheduled for TEP inguinal hernia repair. Since he had elevated liver enzymes, we preferred spinal anesthesia (SA). SA was performed at L3/4 spinal level with 15 mg of plain 0.5% Bupivacaine and 20 mcg Fentanyl. Sedation was provided with IV midazolam 2mg, fentanyl 50 mcg and titrated propofol infusion. After the sensorial block reached level T4, procedure started. Insufflation pressure of 12 mmHg and supine position maintained during the surgery. The patient

was hemodynamically stable and had no complaints throughout the surgery which lasted 90 mins. After the procedure he did not need painkillers for the first 4 hours, was discharged on the 1st postoperative day.

Results SA is not meant to replace GA for TEP but can be used as an alternative for patients who have contraindications for GA. The purpose of this report is to demonstrate that laparoscopic hernia repair can safely and effectively be performed under SA.

Conclusions TEP inguinal hernia repair can be safely performed under SA, and SA was associated with less postoperative pain, better recovery, and better patient satisfaction.

#36329 CASE REPORT: TRANSIENT NEUROLOGICAL SYMPTOMS

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Background and Aims Transient Neurological Symptoms (TNS) are characterized by transient moderate to severe pain at the lower extremities, appearing 2-24h post block reversal. Risk factors include the use of lidocaine/mepivacaine, positioning in lithotomy and knee surgery. Aetiology is unclear, but thought to be related to the neurotoxic effects of local anaesthetics, needle trauma or ischemia. The treatment is symptomatic and prognosis is favourable.

Methods A 75-year-old male, ASA III, insulin dependent diabetes was scheduled for an elective inguinal hernia repair. He had a recent lumbar discectomy with good recovery. The airway evaluation revealed short and wide neck and a 3 cm mouth opening, thus spinal anaesthesia was preferred. Spinal block was performed under sedation (3 attempts), at L3-L4 level, with 10mg isobaric bupivacaine 0.5% and 2 mcg sufentanyl.

Results After blockade reversal, a marked clinical picture characterized by lower limbs (LL) paraesthesia, predominantly in the feet. Pain radiated to the left LL and did not follow radicular territory, associated with LL strength deficit bilaterally (Grade 3 and hypoesthesia throughout the left LL, up to T10). MRI excluded acute conditions and neurosurgery/neurology evaluation pointed to an anaesthesia-related condition. He initiated therapy with dexamethasone and reinitiated ambulatory pregabalin with progressive symptomatic improvement with complete resolution after 10 days.

Conclusions When symptoms surge after central neuraxial block, serious causes such as spinal hematoma, abscess and cauda equina syndrome must be excluded before considering TNS. Despite the risks, regional techniques are safe and useful alternatives to general anaesthesia as in this predicted difficult airway case report.

#36333 CASE REPORT: HERNIA AND BEYOND

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