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).

Application for ESRA Abstract Prizes: I don’t wish to apply for the ESRA Prizes

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 T4, procedure started. Insufflation pressure of 12 mmHg and supine position maintained during the surgery. The patient was hemodinamically 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


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

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 diabetics 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 2mcg 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 radial 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 aa anaesthesia-related condition. He initiated therapy with dexamethasone and reintiated 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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Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page).

Background and Aims Inguinal hernia repair under spinal anesthesia (SA) is commonly performed for GA. The purpose of this report is to demonstrate that 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 T4, procedure started. Insufflation pressure of 12 mmHg and supine position maintained during the surgery. The patient was hemodinamically 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.
Please confirm that an ethics committee approval has been applied for or granted: Not relevant (see information at the bottom of this page)

Application for ESRA Abstract Prizes: I don’t wish to apply for the ESRA Prizes

Background and Aims Use of Ultrasonography (USG) in performing regional blocks is well established. Many anaesthesiologist are still reluctant to use USG to identify landmarks in patients with distorted spinal anatomy. USG is as an effective tool and helps anaesthesiologist to identify various landmark in patients suffering with any kind of spinal deformity. Here we present a case of 52 years old patient posted for Cystoscopy and TURP with a huge right sided lumbar hernia containing right kidney and bowel loops, causing spinal deformity. This case report details the problems faced by anaesthesiologist in positioning the patient, difficulty in administering spinal anaesthesia and how difficult spinal anaesthesia was overcome with use of Ultrasound as guide for identifying various anatomical landmarks.

Methods This is a case report along with review of literature.

Results Experienced anaesthesiologist can visualize neuraxial structures with satisfactory clarity using USG. A preprocedural scan allows to preview the spinal anatomy, identify midline, locate a given intervertebral level, accurately predict the depth to space, and determine the optimal site and trajectory for needle insertion.
Conclusions USG guided neuralgia anesthesia is noninvasive, safe, can be quickly performed, does not involve exposure to radiation, provides real-time images, and is free from adverse effects. USG guided neuralgia anesthesia is a rapidly developing alternative to traditional landmark-based techniques. In experienced hand USG can be an important tool in providing CNB in specific patients. As US technology continues to improve and as skills become more widely available, use of US for CNB may become the standard of care in future.

**Abstracts**

### #36312 VERTICAL NYSTAGMUS AFTER EPIDURAL MORPHINE ADMINISTRATION – A CASE REPORT

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10.1136/rapm-2023-ESRA.326

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

**Background and Aims** Vertical nystagmus is generally associated with cerebellar or brainstem injuries. The most frequently reported complications associated with opioids administered via epidural include nausea and vomiting, itching, and respiratory depression. We describe a clinical case of vertical nystagmus following epidural morphine administration.

**Methods** A 76-year-old patient underwent bilateral breast reduction mammoplasty under thoracic epidural anesthesia with moderate sedation. In the postoperative period, after receiving 2 mg of morphine through the epidural catheter, she developed nausea and vomiting accompanied by visual perception changes. Neurological examination revealed a baseline and gaze-evoked vertical rotary nystagmus without other deficits. A computed tomography scan of the brain showed no acute changes. Assuming iatrogenic opioid-induced nystagmus, a dose of 0.1 mg of naloxone was administered, resulting in complete reversal of the symptoms.

**Results** Cases of nystagmus associated with epidural opioid administration are rare, with only two cases reported in the literature. In the presence of this neurological alteration, it is important to differentiate between structural cerebellar lesions and toxic/pharmacological causes.

**Conclusions** The resolution of symptoms following naloxone administration confirms the diagnosis of a pharmacological iatrogenic cause of vertical nystagmus.

### #36081 CHOICE OF ANESTHESIA FOR HIP FRACTURE SURGERY: A POLL OF ANESTHESIA PRACTITIONERS

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10.1136/rapm-2023-ESRA.327

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

**Application for ESRA Abstract Prizes:** I apply as an Anesthesiologist (Aged 35 years old or less)

**Background and Aims** Large retrospective studies have clearly established the outcome benefits of spinal anesthesia over general anesthesia in patients having hip fracture surgery. However, recent data from a prospective, randomized study (Neuman et al. NEJM 2021) challenged the benefits of spinal anesthesia with regard to survival advantages, the ability to walk independently, and postoperative dementia. We polled the anesthesia community to investigate whether spinal or general anesthesia is perceived as a preferable choice for patients with hip fractures.

**Methods** We solicited a reply to the following question on the NYSORA community page: ‘If you were a patient with a hip fracture and if expertise in both spinal and general anesthesia were available, which anesthetic technique would you choose for your own hip fracture surgery?’ The reply options are listed in figure 1.

**Results** Of 130,000 NYSORA community members, 82% comprised anesthesia professionals. Of these, 4% of the community members posted a reply (5,200 respondents), figure 1. Most respondents (72%) chose spinal anesthesia over general anesthesia for their own hip fracture repair.

**Abstract #36081 Figure 1** Anesthesiology community preference of general vs. spinal anesthesia for their own hip fracture repair

**Conclusions** Although the recent outcome study on spinal versus general anesthesia (Neuman et al., NEJM, 2021) challenged the benefits of spinal anesthesia in patients with hip fracture, our poll suggests that anesthesia practitioners would prefer spinal over general anesthesia for their own hip fracture surgery. These results could have been skewed due to the likely larger prevalence of regional anesthesiologists in the NYSORA community.

### #36089 CONTINUOUS SPINAL ANAESTHESIA – A VALID OPTION FOR A COMPLEX AND FRAIL PATIENT

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10.1136/rapm-2023-ESRA.328

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