

Conclusions Methemoglobinemia is a rare complication associated with prilocaine. Normally higher doses are associated with the development of this syndrome. Sulfasalazine and other drugs administration may enhance the probability of the occurrence of methemoglobinemia. Methylene blue is an effective antidote for methemoglobinemia due to its own oxidizing properties.

#36403 TRACHEAL STENOSIS AND BREAST SURGERY – AN ANAESTHETIC CHALLENGE

Maria Beatriz Maio*, Maria Margarida Telo. *Anesthesiology Department, Hospital da Luz, Lisboa, Lisbon, Portugal*

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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 Regional anaesthesia is frequently the preferred anaesthetic technique in cases of predicted difficult airway, as it avoids approaching the patient's airway. However, choosing the best technique frequently becomes a challenge for some surgeries.

Methods The authors describe the case of a 76-year-old patient undergoing a bilateral breast reduction surgery. She had a history of severe subglottic tracheal stenosis, which required multiple tracheal surgeries.

Results On the preoperative anaesthesia consultation the patient denied respiratory symptoms, no other predictors of difficult airway were identified and otorhinolaryngology observation did not contraindicate the surgery. Nevertheless, a 4.0mm internal diameter cuffed endotracheal tube was used in previous surgeries and a neck CT scan confirmed a 10x10mm subglottic tracheal stenosis; hence, an epidural anaesthesia with moderate sedation was the choice for the anaesthetic technique. On the day of surgery a thoracic catheter was placed at T5-T6 level and 0,4% ropivacaine and sufentanil were administered with a resulting sensory block from T1 to T8. A combination of ketamine and dexmedetomidine was used for sedation. The procedure was uneventful, with no respiratory adverse events.

Conclusions Thoracic epidural anaesthesia can avoid the need to manage the airway in cases similar to the one described. However it is not free of complications, including respiratory muscle paralysis with respiratory depression. Therefore, the level of surgical anaesthesia should be carefully tapered. Accompanied procedural sedation should also be regarded cautiously, as the need to maintain airway reflexes and spontaneous breathing is essential.

#36246 ARISING FROM THE BOTTOM – A RARE COMPLICATION OF A THORACIC EPIDURAL CATHETER

¹Ana Mendes Duarte*, ²Nuno Leiria, ²Rafael Pires, ²Mariana Cortez. ¹*Centro Hospitalar Lisboa Central, Lisboa, Portugal*; ²*Anesthesiology, Centro Hospitalar Lisboa Central, Lisboa, Portugal*

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Background and Aims This case reports a rare thoracic epidural induced priapism and evidences the importance of prompt recognition and treatment to preserve erectile function.

Methods A 44-year-old, male, ASA II, underwent exploratory laparotomy and sigmoidectomy. Prior to general anesthesia induction, a thoracic epidural catheter was inserted at T10-T11. An initial bolus of 7 mL ropivacaine 0.2% was administered and sensory block was distributed from T6 level. No interurrences were reported during the procedure and the patient was transferred to PACU with an epidural infusion of ropivacaine 0.15% at 5 mL/h. An erection was observed 13 hours postoperative. The epidural infusion was discontinued and Urology was consulted. Blood was aspirated from the corpora cavernosa to induce detumescence, which was unsuccessful. An injection of diluted epinephrine was then administered. No more erections were reported after discontinuation of the epidural infusion. The patient was referred to urology consultation and discharged.

Results In our case, we hypothesize that epidural was responsible for the low-flow priapism, considering the absence of direct trauma or hematological disease, uncorrelation of the surgical site with erectile physiology and priapism reversal following discontinuation of the epidural infusion. Priapism has been previously reported as a complication of epidural injection with opioids or in combination with local anaesthesia 1-3.

Conclusions This is a rare complication with unknown incidence and poorly understood pathophysiology. Notwithstanding, prompt identification is vital to prevent permanent damage. Otherwise, it may lead to emergency intervention as described here. Awareness must be raised regarding epidural-induced priapism to ensure early identification.

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#35866 CONTINUOUS SPINAL ANESTHESIA IN HIGH-RISK PATIENT: A CASE REPORT

António Ladeira, Catarina Petiz*, Patrícia Conde. *Anesthesiology, Centro Hospitalar Universitario Lisboa Norte, Lisbon, Portugal*

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Background and Aims Continuous spinal anesthesia (CSA) is particularly useful in lower limbs surgery in patients with cardiovascular and respiratory comorbidities.

Methods A 74-year-old male, BMI 27 Kg/m², ASA IV status, was scheduled for urgent supragenicular amputation due to critical ischemia of the left lower limb. The patient had a history of type II diabetes mellitus, hypertension, heart failure (ejection fraction of 34%) NYHA III, atrial fibrillation, recent pulmonary embolism, and COPD. The patient was under anticoagulants, antiarrhythmics, anti-hypertensives, bronchodilators, and oral hypoglycemic agents. Laboratory analysis showed Hb 10.6 g/dL, no coagulation abnormalities (LMWH was stopped for 24 hours) and normal renal function. The patient was alert, eupneic without supplemental oxygen and hemodynamically stable. The patient was proposed for CSA with standard ASA and invasive blood pressure monitoring