

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

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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

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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 anaesthesia1-3.

Conclusions This is a rare complication with unknown incidence and poorly understood pathophysiology. Nonwithstanding, 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

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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

Results A Tuohy needle was placed at L3/L4 level and the catheter was inserted 4 cm into the subarachnoid space. One milliliter of bupivacaine 0.5% was administered, achieving a T8 block within 10 minutes; a repeated dose of 0.5 ml was given 45 minutes later. The surgery proceeded without complications. Hemodynamic stability was maintained without the need for vasopressor support. At the end of surgery, 100mcg of morphine was given through the catheter and the intrathecal catheter was removed.

Conclusions In this case, CSA was an effective and safe option for a high-risk surgical patient. The advantage (over single-shot spinal anesthesia) to adjust the level of anesthesia and prolong its duration, with lower doses of local anesthetics, reduced the risk of complications such as hypotension and respiratory depression.

#34665 CONTINUOUS SUBARACHNOID BLOCK IN A CASE OF HYPERTROPHIC CARDIOMYOPATHY – CASE REPORT

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Background and Aims Hypertrophic Cardiomyopathy (HCM) is characterized by marked hypertrophy of the myocardium and it's frequently accompanied by dynamic left ventricular outflow tract (LVOT) obstruction. Although patients with HCM may not demonstrate LVOT obstruction under basal conditions, dynamic obstruction can develop with the administration of anesthesia. Classically, LVOT obstruction has been considered a relative contraindication to neuraxial anesthesia.

Methods We report a case of a successful continuous subarachnoid block (CSB) in a 66-year-old, ASA III, female patient with HCM proposed for urgent right ankle fracture surgery. Pre-operative transthoracic echocardiogram showed asymmetrical left ventricular hypertrophy and a peak LVOT gradient of 13mmHg at rest and 67mmHg with Valsalva manoeuvre. After informed consent and placement of invasive arterial pressure monitoring, premedication with 1mg of midazolam was conducted. An ultrasound-guided popliteal sciatic nerve block with 20mL of 0,375% ropivacaine was performed on the right leg followed by placement of a subarachnoid catheter at the L3-L4 level. A total of 2,5mg of 0,5% levobupivacaine and 0,003mg of sufentanyl were injected into the subarachnoid space. The surgery was uneventful and the patient remained hemodynamically stable. No complications were reported and the patient was later discharged home.

Results In our case the execution of a CSB allowed for titration of local anesthetic dosage, which permitted hemodynamic stability while giving optimal anesthetic effect. We also believe the use of premedication as well as peripheral nerve blockade for perioperative analgesia contributed to the overall success of this case.

Conclusions Anesthesiologists must understand the pathophysiology of this disease, as LVOT obstruction can cause life-threatening hemodynamic instability.

#36082 A POLL ON SAFETY OF SPINAL ANESTHESIA IN PATIENTS WITH AORTIC STENOSIS

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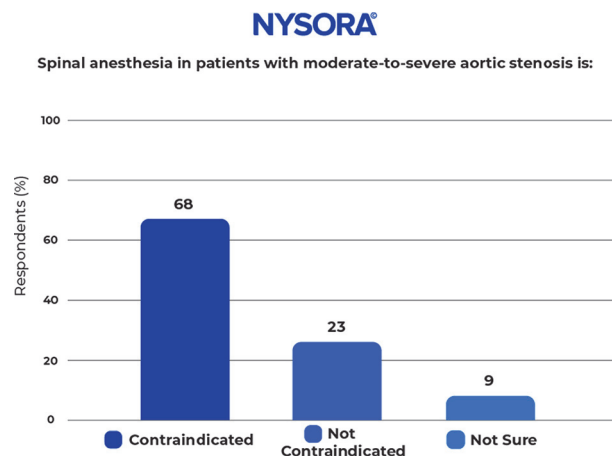
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Application for ESRA Abstract Prizes: I apply as an Anesthesiologist (Aged 35 years old or less)

Background and Aims The use of central regional anesthesia is traditionally regarded as contraindicated in patients with severe aortic stenosis (AS) due to the risk of hypotension, decreased coronary perfusion, and acute myocardial ischemia. However, there is no high-level literature evidence in support of this recommendation. Since cardiovascular monitoring systems, diagnostics, pharmacology, and clinical practice patterns have improved, we polled anesthesiology practitioners to gauge their opinion on whether spinal anesthesia should remain contraindicated in patients with moderate-to-severe AS. **Methods** We surveyed the anesthesiology community of NYSORA to assess practitioners' perception of whether or not spinal anesthesia is contraindicated in patients with moderate-to-severe AS (the definition according to the 2014 AHA/ACC guidelines for the severity of AS).

Results A total of 130.000 NYSORA community members were polled. Of these, 82% comprised anesthesiology practitioners. A total of 1,400 (1.1%) community members posted a reply, figure 1. Most respondents (68%) opined that spinal anesthesia is contraindicated in patients with moderate-to-severe AS.



Abstract #36082 Figure 1 NYSORA community poll results

Conclusions Our poll results suggest that anesthesia practitioners continue to consider spinal anesthesia as contraindicated in patients with moderate-to-severe AS, although neuraxial anesthesia may be associated with better outcomes (e.g., in patients having joint replacement surgery). In view of the advances in monitoring and possible advantages of spinal