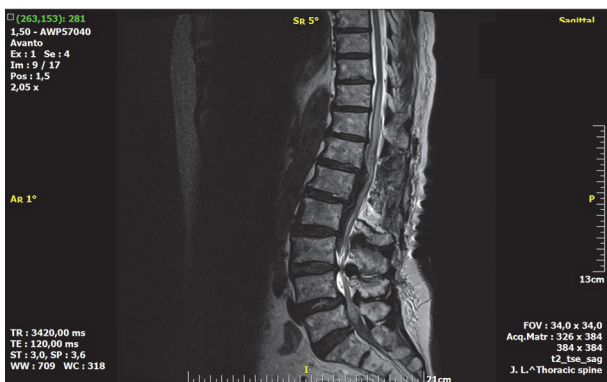




Abstract #36293 Figure 1 MRI: L1 spinal epidural hematoma



Abstract #36293 Figure 2 Postoperative MRI

**Conclusions** Anesthetists and surgeons, as a team must be alert for the possibility of SEH whenever neurological symptoms occur in the postoperative period, especially after a neuraxial blockade which can be connected to this complication. MRI is the preferred diagnostic method and early surgical intervention is associated with optimal neurological outcomes.

### #36436 CAUDAL ANALGESIA FOR RADICAL ROBOTIC PROSTATECTOMY

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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** Radical robotic prostatectomy is increasingly popular. Our aim was to evaluate the analgesic requirements post radical robotic prostatectomy performed under general anaesthesia with caudal block.

**Methods** An audit was conducted between April 2008 and October 2018. 896 patients who underwent radical robotic

prostatectomy received a standard general anaesthetic (paracetamol 1 gm, ondansetron 4mg, dexamethasone 6.6mg fentanyl 100microgram, propofol, desflurane and atracurium infusion) with caudal analgesia containing 40ml 0.25% bupivacaine, 150 micrograms clonidine and 100 micrograms fentanyl. Regular paracetamol was prescribed post-operatively, oral morphine 20mg 3 hourly, cyclizine and ondansetron were available on an 'as required' basis. Visual analogue scale (VAS) score, analgesic consumption and the incidence of side effects were recorded at 30 min and 24 hours post-surgery.

**Results** 24 (3%) patients required additional intraoperative morphine. Only 136 (15%) had a VAS greater than 3/10 post-operatively with the highest being 8/10 in 8 patients. All patients received regular paracetamol. 148 (17%) required oral morphine within the first 24 hours post-operatively. Only 68 (8%) patients required intravenous morphine (10-20mg) in recovery. There were no major side effects associated with the caudal block. 112 (12.5%) suffered post-operative nausea and vomiting. Mean inpatient stay was 29.4hrs.

**Conclusions** A general anaesthetic with caudal block provides excellent intra- and post-operative analgesia with minimal side effects. This has important implications in terms of patient satisfaction, minimising side effects and facilitating early hospital discharge.

### #36523 ULTRASOUND-GUIDED SUPERIOR CLUNEAL NERVES BLOCK FOR NEUROPATHIC PAIN

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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** Superior cluneal nerves (SCN) originate from the dorsal rami of lower thoracic and lumbar spinal nerves by their lateral cutaneous branches and provide sensory innervation of the posterior iliac crest, superior gluteal region and greater trochanter. A reliable SCN block may have application in management of chronic lower back pain, which has a high prevalence and frequently a neuropathic pain component. In this case report, we describe the use of ultrasound-guided SCN block technique for the management of chronic neuropathic post-herpetic pain located on lower back and gluteal region, refractory to initial pharmacological and topical treatment strategies.

**Methods** Male patient, 39 years-old presents with post-herpetic neuralgia and complaints of unilateral lower back and gluteal pain, with allodynia, burning and stabbing in affected area, NRS 6 and DN4 questionnaire 6/10. Initial pharmacological treatment with amitriptyline, gabapentin and tramadol with no adequate pain relief. Three topical capsaicin attempted with only partial relief, so an ultrasound-guided SCN block was performed with ropivacaine 0,2% and triamcinolone, with mapping of cutaneous allodynia area. Minutes after nerve block there was a significant reduction of the area, with pain intensity successfully decreased.



**Abstract #36523 Figure 1** Area of pain before (blue) and after (green) ultrasound-guided SNC block technique

**Conclusions** Neuropathic pain is a major form of chronic pain with profound physical and psychological impact and it's often challenging to manage due to its diversity of mechanisms and patients' responses. In this case the SCN block provided the patient an effective pain relief due to the nerves contribution to the affected area, perhaps underlying a neuropathy-mediated SCN pain, which may benefit of longer relief with radiofrequency.

### #35977 PERIPHERAL NERVE STIMULATION IMPLANT FOR CHRONIC POST-TRAUMATIC HIP AND PELVIC PAIN

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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** We present a case of a 67-year-old female with a history significant for a mechanical fall causing injury to her lumbar spine and pelvis resulting in hip and pelvic pain. Nine months after her injury, X-ray imaging demonstrated hypertrophic non-union of the right iliac wing fracture and displacement of pubic symphysis and right sacroiliac joint. She had pain in her low back, which radiated to the right lateral aspect of the buttock and groin, and pelvic pain. She was unable to consider surgery and her pain was not well managed with medications, thus she presented to the pain management clinic.

**Methods** The patient underwent diagnostic obturator and femoral articular nerve branch injections and she also a middle cluneal nerve steroid injection under fluoroscopic and ultrasound-guidance and reported improvement in her pain. She had a peripheral nerve stimulator (PNS) trial and subsequent implantation with leads to the right middle cluneal nerve and right obturator and femoral articular nerve branches.

**Results** The patient reported significant relief in both the posterior and anterior distribution of her pain. Her ADLs improved with PNS implantation and she reported that she is now able to sleep without pain.

**Conclusions** Through the use of combined fluoroscopy and ultrasound we were able to safely target the middle cluneal nerve and the obturator and femoral articular nerve branches. We were able to reliably replicate the patient's pain distribution with neurostimulation before permanently implanting the PNS. This case demonstrates the successful use of PNS in treating chronic post-traumatic hip and pelvic pain.

**Attachment** pns.pdf

### #36063 WHEN THE THORACIC MRI EXPLAINS THE UPPER EXTREMITY SYMPTOMS

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

**Background and Aims** Syringomyelia is characterized by the presence of spinal cord cavitation. It has multiple causes and is most commonly seen in association with Chiari I malformation. In these patients, the distribution of symptoms sometimes correlates with the anatomical location of the spinal cavitation. Dyesthesia is found in slightly less than half of the patients and it responds unpredictably and often poorly to currently available treatments. We present a case in which the dyesthesia could have been attributed to cervical syringomyelia, but the cause of this spinal finding remained elusive.

**Methods** 36-year-old female with history of Meniere's disease and carpal tunnel syndrome presenting with numbness and tingling in her right arm and bilateral lower extremities for 1 year. She also reports having pain in her right arm, but not her legs. An MRI of the cervical spine showed central and right paracentral cervical spinal cord edema with small caliber syrinx from the levels of upper C3 through C6/7, moderate sized syrinx with the right hemi cord at C7 and partially visualized large multiseptated syrinx within the upper thoracic spinal cord from T1-T4. Her brain MRI ruled out Chiari's malformation. A thoracic MRI found continuation of the syrinx and a mass at the level of T9. The patient underwent resection of the mass.