

#36497 BOTULINUM TOXIN INFILTRATION AS AN OPTION FOR TREATMENT OF PERSISTENT HEADACHE ASSOCIATED WITH COVID-19. 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 apply as an Anesthesiologist (Aged 35 years old or less)

Background and Aims Different descriptions of long COVID have already been proposed, and the most common description includes symptoms lasting for over three months after the first symptom onset. One of the most frequent symptoms identified, besides fatigue and dyspnoea, is a new daily persistent headache. We describe a case of persistent headache associated with COVID-19, which had a poor response to pharmacological treatment. The patient scored a pain of 8 points in Visual Analog Scale (VAS). It was a widespread—affecting frontal, temporal, and occipital area—pulsating quality headache that worsened with mild physical activity.

Methods Since Botulinum toxin type A has been used to treat chronic migraine for over a decade, we decided to try this therapeutic option after proving that the response to local anesthetics was positive. She responded satisfactorily to bilateral greater occipital nerve block and infiltration of the frontal and temporal muscles with local anesthetic and corticosteroids, with an improvement during approximately 48 hours. Two weeks later, we administered by ultrasound guidance 20 IU of botulinum toxin near the greater occipital nerve, and performed a mapping with botulinum toxin by administering it at different points: both trapezius, splenius, frontal muscles, bilateral orbicularis and bilateral temporal and parietal muscles

Results After seven days, the patient reported improvement of the symptoms (VAS 3) that were still present one month later. **Conclusions** In conclusion, we propose that botulinum toxin can be a therapeutic option for persistent headaches associated with COVID-19. However, future research studies are required to clarify this possibility.

#36245 TREATMENT OF NEUROPATHIC PAIN WITH PERIPHERAL NERVE BLOCK: CASE REPORT

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Background and Aims Intraoperative nerve injuries caused by the patient's positioning are surgery's undesirable complications, that might occur despite preventive measures and lead to sensory and motor deficits and neuropathic pain. This work aims to describe a clinical case of a patient who developed neurological deficits in the territory of the common

peroneal nerve (CPN) after a meningioma's excision. The patient gave consent to this clinical case presentation.

Methods A 49-year-old woman underwent a temporal meningioma removal. In the postoperative period, the patient developed incapacity of dorsiflexion of the feet bilaterally and intense neuropathic pain (8/10), with a daily sensation of electric shocks and burning. The electromyography test revealed signs of bilateral involvement of the CPN, above the peroneal head, with severe axonal damage, more significantly at the left side. The patient was initially prescribed with a therapeutic plan that included gabapentin and physiotherapy, showing mild benefits. However, although presenting a moderate improvement of the neuropathic pain, the patient maintained a relevant and disabling clinical condition. Therefore, a peroneal nerve block (PNB) was proposed.

Results The patient underwent an ultrasound-guided bilateral PNB, administering 2 ml of 0.2% ropivacaine and 20 mg of methylprednisolone on each side. The patient described an immediate improvement in the neuropathic pain score (2-3/10) and could walk without crutches. In the following months, the patient referred a sustained improvement in the pain score and autonomy.

Conclusions These results show that ultrasound-guided blockade using 0.2% ropivacaine and methylprednisolone could be a safe and effective treatment in patients with nerve injury and neuropathic pain.

#36418 POSTERIOR PERICAPSULAR DEEP-GLUTEAL BLOCK IN ADDITION TO THE PENG BLOCK FOR CHRONIC HIP PAIN: A CASE REPORT AND CLINICAL OUTCOMES

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Background and Aims Hip osteoarthritis management primarily focuses on rapid symptom control including pain alleviation and functional improvement. Ultrasound-guided regional anesthesia techniques targeting the branches of the anterior lumbar plexus have been performed in providing pain relief in chronic hip pain. However, despite these approaches, patients may experience residual posterior hip pain, which can be attributed to the posterior nerve supply of the hip. We present a case report of chronic hip pain successfully managed with posterior pericapsular deep-gluteal (PPD) block in addition to pericapsular nerve group (PENG) block.

Methods A 56-years old patient with a history of total hip arthroplasty presented to our pain clinic. In spite of medication and physiotherapy management, the patients' numeric rating score was 6 at rest and 8 during movement. After three repeated PENG blocks within a one-month period, the pain localized to the posterior hip region. Consequently, we decided to perform PPD block (figure 1). Written consent was obtained from patient for the procedure and future publication.

Results After administering the PPD block in addition to the PENG block, the patients' NRS scores decreased to 2 at rest

and 4 during movement. Additionally, the patients' functional capacity scores showed improvement (table 1).

Conclusions An additional PPD block can be beneficial in patients with residual posterior hip pain, even when anterior approaches have been performed. We suggest that PPD block targeting the superior gluteal nerve, nerve to the quadratus femoris muscle, and sciatic nerve in addition to the PENG block can be performed for more complete analgesia in chronic hip pain.

#35733 AN EPISODIC CASE OF SHORT LASTING UNILATERAL NEURALGIFORM HEADACHE WITH CONJUNCTIVAL INJECTION AND TEARING (SUNCT) AFTER OPHTHALMIC SURGERY

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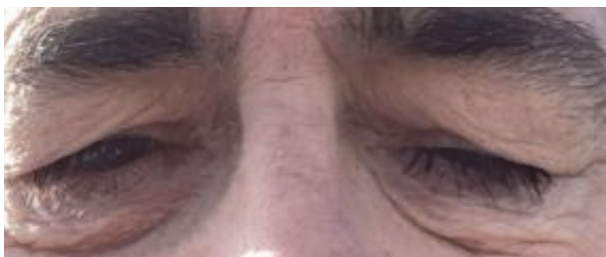
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Background and Aims Short-lasting unilateral neuralgiform with conjunctival injection and tearing (SUNCT) is a rare cause of facial pain. It has been associated with vascular abnormalities, intracranial masses and trauma but can occur de novo. We share a case of SUNCT which presented after surgery for retinal detachment.

Methods The patient was followed up weekly over telephone consultation. A pain and symptom diary was kept until resolution.

Results A 64 year old man underwent retinal surgery for retinal detachment under sub-tenons block. His past medical history included migraine with aura and ocular migraine. On the evening of day 0 the attacks began to occur. They were described as lasting 45-60 seconds total with a maximum severity on the numerical rating scale (NRS) of 9. The pain built up in a crescendo during the attack and the pain was described as stabbing and spasmodic in the orbital region. There was associated autonomic features which included conjunctival injection, tearing, rhinorrhoea, forehead sweating and ptosis. Neuropathic features included hypersensitivity over the ipsilateral forehead. During the cluster of attacks, another could be initiated through palpation over the orbital and temporal region. There were 50-100 attacks daily which clustered over 3-4 hour periods typically in the evening. He was reviewed by the eye clinic on day 1 who advised cyclopentolate and ibuprofen to no effect. The attacks resolved by day 16.



Abstract #35733 Figure 1 Left sided Ptosis Day 14

Conclusions SUNCT can be initiated by peripheral causes as suggested here and in the literature. Therefore it may be an underreported problem after ophthalmic and craniofacial surgery.

Attachment DH SUNCT ptosis.pdf

#36496 MANAGEMENT OF POST-PAIN PROCEDURE HICCUPS: A SYSTEMATIC REVIEW

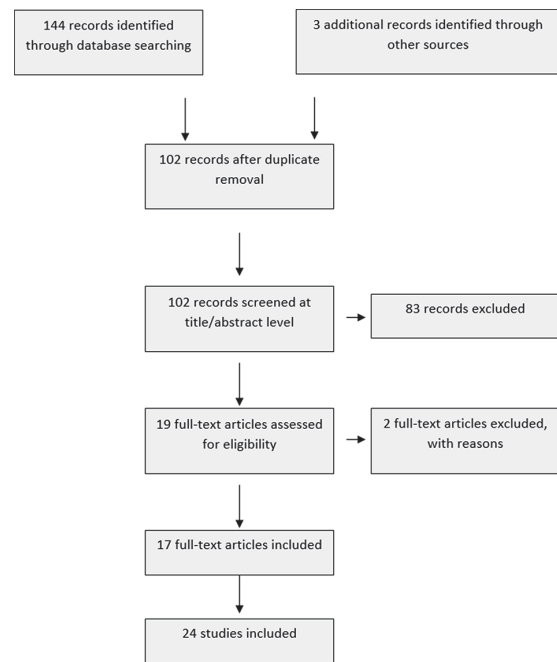
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Background and Aims Hiccups, which can be quite debilitating, have been reported after interventional pain procedures (IPPs); however, the association between the two remains unexplored.

Methods A comprehensive search was carried out in PubMed, Cochrane, Ovid, and DOAJ to identify case reports and case series reporting the occurrence of hiccups after IPPs since inception to May 27, 2023. Two reviewers parallelly screened the studies using predetermined inclusion and exclusion criteria. After quality assessment, a standardised template was used to extract data from each study, including study characteristics and type of IPP; approach, region, and drugs used in the procedure; management details; and outcome. A descriptive analysis of the extracted data was then carried out. Chi-square tests of association and Fisher's exact tests were conducted where appropriate.



Abstract #36496 Figure 1 PRISMA flow diagram depicting the study selection process