The patient was taken to the post-anesthesia care unit and angiographic imaging was planned as an emergency. Selective right lumbar artery angiography and embolization were applied to the L4 level by the interventional radiology team. Control abdominal ultrasound revealed no active bleeding. The vital signs of patient was stable and discharged after 2 days. He had no pain but nausea and fatigue. Follow up for hemodynamic state is going on.

Abstract #36320 Figure 1  CT imaging of the hematoma area observed at the level of the 4th lumbar vertebra. It measured 16 cm in widest diameter

Abstract #36320 Figure 2  Angiographic imaging of active bleeding from the distal lumbar artery

Abstract #36320 Figure 3  Leakage in the lumbar artery stopped after embolization and was confirmed by angiographic imaging

Conclusions Interventional pain procedures around spine demand extra care to avoid the aorta related vascular structures. Lumbar artery injury after sympathetic block is a rare complication and selective angiography and embolisation is a life saving procedure.

Abstract #35874  CAUDAL-EPIDURAL PRF IN COMBINATION WITH LUMBAR SYMPATHETIC BLOCK AND INTRATHECAL DEXMEDETOMIDINE FOR INTRACTABLE MALIGNANT PSOAS SYNDROME PAIN: CASE REPORT

Ayda Turkoz, Nigar Kangarli*, Gulpinar Tepe. Anesthesiology and Reanimation, Bezmialem Vakif University, Istanbul, Turkey

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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 Malignant psoas syndrome (MPS) is associated with proximal lumbosacral plexopathy and characterized by severe intractable pain, despite multi-modal medical treatment. Spinal dexmedetomidine and lumbar sympathetic nerve block in combination with Pulsed radiofrequency (PRF) are rarely performed for intractable lumbosacral plexopathy pain. We present a combination of spinal dexmedetomidine, lumbar sympathetic nerve block and caudal-epidural PRF in the management of MPS, refractory to medical and physical treatment.
Methods A 49-years old female with recurrent lung adenocarcinoma, admitted with severe shooting and burning right groin pain with radiation to the thigh and weakness of quadriceps at motion. She was managing her pain with number of opioids, including oxycodone, morphine, fentanyl, and intra-muscular meperidine. The total oral morphine equivalent opioid dose equaled 300-400 mg. For the first month after admission, we successfully palliated pain with spinal dexmedetomidine and simultaneously reduced patient’s opioid addiction. On the second month, bilateral lumbar sympathetic plexus block at L3-L4 with additional caudal-epidural PRF, led to significant reduction in her thigh pain VAS score to 4/10. In addition, improvement in quadriceps functionality and sleep quality, along with remarkable reduce in analgesic opioid doses, earned patient high satisfaction.

Results Intrathecal dexmedetomidine infusion allowed successful pain resolution with average VAS of 3-4/10 for 1 month. Caudal-epidural PRF with sympathetic block sustained painless palliative period at stable VAS of 4-5/10.

Conclusions Spinal dexmedetomidine, caudal-epidural PRF and lumbar sympathetic plexus block can be an innovative therapeutic option in the management of Malignant psoas syndrome, acquired due to lumbosacral plexopathy.

Abstract #33935 COMPLETE RESOLUTION OF CENTRAL NEUROPATHIC PAIN AFTER LEFT FRONTAL CEREBRAL HEMORRHAGE: A CASE REPORT

Seonjin Kim*, Jeong Eun Lee, Sam Soon Cho. Department of Anesthesiology and Pain Medicine, Veterans Health Service Medical Center, Seoul, Korea

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 Central neuropathic pain syndrome is a neurological complication associated with central nervous system damage. Although the pathophysiology of central neuropathic pain has yet to be elucidated, dysfunction of spinal-thalamic-cortical pathway is critical for the development of central neuropathic pain. We present a case of refractory central neuropathic pain resulting from tumor resection of anterior cingulate gyrus that resolved after frontal cerebral hemorrhage.

Methods We assessed this gentleman’s pain by assessing his Visual Analogue Scale (VAS) and reviewing previous management strategies, current medication and impact of the condition on his life. Brain and spine MRI were performed to find the cause of the pain.

Results A 62-year-old man presented with central neuropathic pain in both upper and lower extremities resulting from resection of anterior cingulate gyrus glioma. Pain was 8/10 on the VAS with significant impact on the patient’s psychological well-being. Despite epidural blocks, medications, and cervical/lumbar spinal cord stimulator over a 10-year period, only 30% of the pain was relieved. However, after the surgery for left superior frontal gyrus hemorrhage caused by a slip-down injury, his symptoms were completely resolved.