

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 intramuscular 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.

#34485 CAUDAL BLOCKADE IN CHRONIC LOW BACK PAIN – A CLINICAL CASE REPORT

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10.1136/rapm-2023-ESRA.373

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Background and Aims Caudal epidural blockade (CEB) is a technique also used in chronic pain management. Although fluoroscopy is the gold standard technique, ultrasound gained popularity due to its high success rates, accessibility and lower radiation exposure.

Methods 53-year-old man with low back pain radiating to his right leg for six months with paresthesias, difficulty in gait and decreased sleep quality. Lumbar MRI revealed disc protrusions at levels L4-L5, L5-S1 and electromyography showed signs of acute on chronic root distress of the right L5 nerve. One month of physiotherapy and oral analgesia showed no improvement and the patient was waiting for a neurosurgery consultation. We proposed a CEB which the patient consented to.

Results CEB was performed with the patient in prone and standard ASA monitoring. The sacral hiatus was identified using a linear probe in transverse and longitudinal planes. An ultrasound-guided longitudinal in-plane approach was performed using a 21G needle. After puncturing the sacrococcygeal ligament a solution of 2mL 2% lidocaine, 6mg betamethasone and 8mL saline was administered. Unidirectional flow was confirmed using color Doppler mode. No complications were reported. One month later, the patient returned reporting marked pain relief, normalized gait pattern, and reduced frequency of physiotherapy. He had the

neurosurgery consultation, but surgery was delayed due to lack of clinical criteria. After four months the patient remained pain-free.

Conclusions -Ultrasound demonstrates high success rates in CEB. -Ultrasound allows for lower radiation exposure with more accessible equipment. -CEB is effective in treating refractory low back pain and can delay or avoid more invasive procedures.

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

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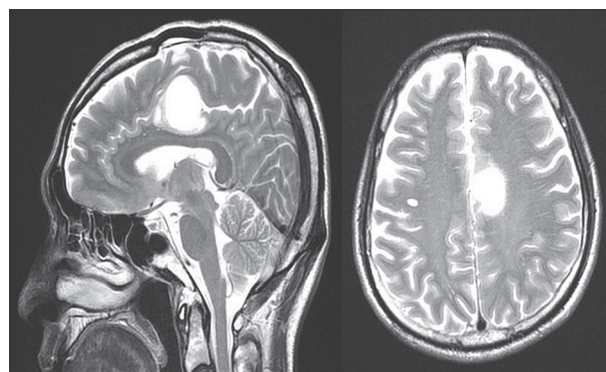
10.1136/rapm-2023-ESRA.374

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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.



Abstract #33935 Figure 1 Recurrent low-grade glioma (3 cm diameter) diagnosed in 2012 (sagittal and transverse MRI T2 images)