Conclusions

Compared to other hospital visits, surgery can be stressful. Acupuncture is a safe, non-invasive way for nosocomephobia patients to manage preoperative anxiety and undergo elective surgery.

POMAH – PERIOPERATIVE MANAGEMENT OF PATIENT WITH HIP FRACTURE IN CENTRO HOSPITALAR UNIVERSITÁRIO LISBOA NORTE (CHULN)

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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

Proximal femoral fractures (PFF) are an important public health problem in industrialized societies, affecting older, mainly female, patients who are more likely to suffer from osteoporosis. PFF are associated with increased morbidity and functional impairment with a negative impact on patient’s quality of life. Nearly always, PFF requires hospitalisation, permanently disables 50% of patients and a 26% one-year mortality rate, in elderly patients, has been described. The National Institute for Health and Care Excellence (NICE) recommends that patients with a hip fracture should have surgery within 36 hours of admission to hospital. In CHULN, we elaborated a protocol that allows patients to have surgical intervention within 36-48 hours, creating a multidisciplinary patient-centered approach, optimizing their clinical status and enhancing their recovery.

Methods

POMAH has the following principles

1. Preoperative patient medical optimization according to clinical protocols
2. Early pain control with regional anesthesia
3. Nutritional protocols with liquid intake up to 2h before surgery and protein reinforcement
4. Surgical intervention within 36-48h
5. Perform chemical neurolysis to control pain in patients who lack surgical indication
6. Early rehabilitation since day1

Abstract #35044 Figure 2 Major themes co-occurrence

Abstract #35044 Table 1 A summary of major themes and related subthemes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Acupuncture</th>
<th>Medical History</th>
<th>Mental State</th>
<th>Personal History</th>
<th>Nosocomephobia</th>
<th>Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>X</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Medical History</td>
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<td>X</td>
<td>0</td>
<td>6</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Mental State</td>
<td>5</td>
<td>0</td>
<td>X</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Personal History</td>
<td>1</td>
<td>6</td>
<td>1</td>
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<td>3</td>
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<tr>
<td>Nosocomephobia</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>4</td>
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<tr>
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<td>3</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>X</td>
</tr>
</tbody>
</table>

Note. The highest number of overlaps was 5 and the lowest was 0 or no overlap.
Performing general anesthesia we should consider use of reversal agents or specific tests.

**Abstract #35617 Table 1** Perioperative management of main antithrombotic drugs in hip fracture surgery

<table>
<thead>
<tr>
<th>Drug</th>
<th>INTERUPT/MPPT</th>
<th>MANAGEMENT</th>
<th>NEURAXIAL ANAESTHESIA</th>
</tr>
</thead>
</table>
| Aspirin       | NO            | Not delay surgery | With Apixaban < 200 mg
|              |               |            | neuroaxial anesthaesia can be performed |
| Clopidogrel   | YES           | Not delay surgery | With Apixaban < 200 mg
|              |               |            | General anesthaesia is prefered, if risk of general anesthaesia ask for specific platelet test |
|      |              |              |            | General anesthaesia is prefered, if risk of general anesthaesia ask for specific platelet test |
|              |              |              |            | General anesthaesia is prefered, if risk of general anesthaesia ask for specific platelet test |

**Conclusions**

Early hip fracture surgery is safe in patients taking anticoagulant/antiplatelet drugs. Special attention should we pay in periopeative timing when neuraxial anesthesia is performed.

**Abstract #35961 COMBINED ANESTHESIA FOR TRANSABDOMINAL VERTICAL RECTUS ABDOMINUS MUSCULOCUTANEOUS FLAP**

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**Background and Aims**

Pain management for Vertical Rectus Abdominis Musculocutaneous (VRAM) Flap can be challenging due to a large surgical incision. We present a case of a 65-year-old female admitted for correction of rectivuate complex urogenital prolapse and VRAM Flap. We aim to demonstrate the benefits of combined anesthesia for this type of surgery.

**Methods**

An epidural catheter was placed at L3/L4 level with an initial bolus of 10ml of 0.75% ropivacaine administered without relevant hemodynamic instability. After induction of total intravenous anesthesia (propofol and remifentanil), 2mg of epidural morphine was administered to spread the analgesia. Another bolus of 7 ml of 0.2% ropivacaine was administrated only 5h after. The maintenance dose of remifentanil was low (up to less than 0.05-0.10 mcg/kg/min).

**Abstract #35825 KEY PATHOPHYSIOLOGIC PATHWAYS IMPLICATED IN FABRY’S PAIN CRISSES**

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