

performing general anesthesia we should consider use of reversal agents or specific tests.

Abstract #36517 Table 1 Perioperative management of main antithrombotic drugs in hip fracture surgery

	INTERRUPT	MANAGEMENT	NEURAXIAL ANESTHESIA
Aspirin	NO	Not delay surgery	With Aspirin < 200 mg neuroaxial anesthesia can be performed
PY12 Inhibitors	Yes (not if patient with high thrombotic risk)	Not delay surgery (check for bleeding, reserve platelets)	General anesthesia is preferred. If risk of general anesthesia ask for specific platelet test.
AVK	Yes (if high thrombotic risk patient add heparin as bridge therapy)	- Reverse with vitamin K and check INR - With INR >1,8 proceed with surgery - Consider PCC for rapid reversal	With INR < 1,5 neuraxial anesthesia can be performed Consider reversal with PCC if risk of general anesthesia
Dabigatran	Yes Check renal function	Surgery can be performed first 24-36 hours (if renal function impaired FG < 30 consider check specific test)	First 24 hours perform general anesthesia. If risk of general anesthesia ask for a specific coagulation test (normal dTT or or [] < 30 ng/ml) or consider reversal with idarizicumb (out of guidelines).
AntiXa (Apixaban, edoxaban, rivaroxaban)	Yes Check renal function	Surgery can be performed first 24 hours (if renal function impaired FG < 15 consider check specific test)	First 24 hours perform general anesthesia. - If risk of general anesthesia ask for a specific coagulation test (AntiXa < 0,1 IU/ml-1 o [] < 30 ng/ml). Or consider reversal PCC (out of guidelines)

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

#35961 COMBINED ANESTHESIA FOR TRANSABDOMINAL VERTICAL RECTUS ABDOMINIS 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 recidivate complex uterovaginal 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 remifentanyl), 2mg of epidural morphine was administered to spread the analgesia. Another bolus of 7 ml of 0.2% ropivacaine was administered only 5h after. The maintenance dose of remifentanyl was low (up to less than 0,05-0,10 mcg/kg/min). Analgesia was complemented with ceterolac 30mg, paracetamol 1g and metamizol 2g. The procedure lasted for 7 hours and at the end, a patient-controlled epidural infusion (PCEA) was connected

with 0,1% ropivacaine with a continuous infusion of 5ml/h and 4ml patient-controlled bolus with a lockout of 20min.

Results Post-operative pain was well controlled, 2 out of 10 (numerical rating scale pain) at rest and movement at 0h and 12h without bolus attempts in the PCEA nor opioid rescue analgesia.

Conclusions Patient-controlled epidural infusion limited postoperative opioids necessities and their associated side effects while providing controlled analgesia in VRAM flap surgeries.

#36092 DEXMEDETOMIDINE IN PALLIATIVE CARE

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Background and Aims Delirium is common in the terminal patient. It increases discomfort for the patient and relatives. The agents used to treat delirium are various antipsychotics, which are not always effective. Dexmedetomidine intranasal application was effective.

Methods A case report of a palliative patient who developed a severe delirium well treated by the dexmedetomidine.

Results A 42-year-old cancer patient was developed a severe delirium. Delirium did not subside with the antipsychotics. Dexmedetomidine intranasal application 1 mcg/kg. The patient became completely calm and his previous neuroleptic and sedation therapy could be withdrawn. In the following days, he reacted sensibly and responded to instructions, his day-night rhythm was restored.

Conclusions Palliative care is becoming an important area of medicine in where also anaesthesiologists participate. With our knowledge and experience, we can contribute a lot to better treatment of pain, as well as other conditions such as delirium and the need for patient sedation. In order to treat patients well, it is important to be familiar with medications and techniques, so it is important to apply our knowledge from operating theatres and ICUs to palliative care. Dexmedetomidine is a potentially useful drug for the targeted treatment of pain and delirium in the tertiary palliative care setting. When used for sedation and delirium treatment, dexmedetomidine fits with the patient's, family's and physician's goals of care when patient alertness and participation in conversations with loved ones and healthcare care personnel are important at the end of life.

#35825 KEY PATHOPHYSIOLOGIC PATHWAYS IMPLICATED IN FABRY'S PAIN CRISES

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