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

	INTERRUMPT	MANEGEMENT	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 prefered. 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 idarizicumab (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 we 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 remifentanil), 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 remifentanil was low (up to less than 0,05-0,10 mcg/kg/min). Analgesia was complemented with cetorolac 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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Please confirm that an ethics committee approval has been applied for or granted: Yes: I'm uploading the Ethics Committee Approval as a PDF file with this abstract submission

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

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

Results A 42-year-old cancer patient was developed a severe dellirium. Delirium did not subside with the antipsychotics. Dexmedetomidine intranazal 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, soit 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 inthe 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 healhealth care personnel are important at the end of life.

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

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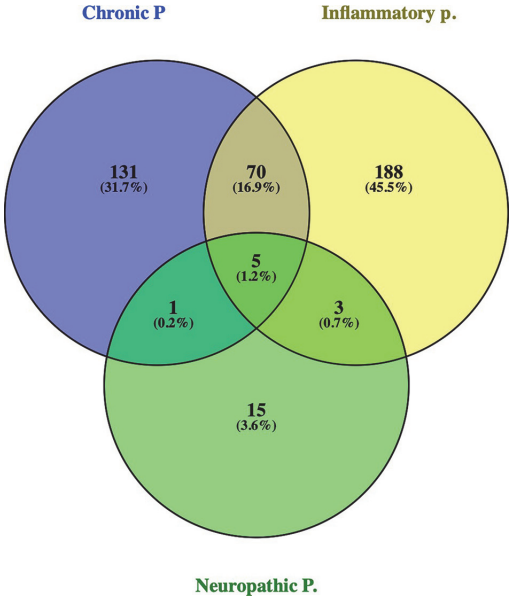
Background and Aims Fabry disease is an X-linked disorder caused by mutations in the GLA gene, leading to globotriaosylceramide (Gb3) accumulation on the lysosome. Patients experience numerous forms of pain, including evoked and chronic pain. The exact cause of the pain has yet to be entirely understood. Still, the peripheral nervous system, cardiac, renal, sensory, and autonomic ganglion cells are particularly affected by the deposits of Gb3.

Methods A bioinformatic analysis of likely genes related to and signaling pathways involved in the manifestation of pain in Fabry disease was performed. A literature review on possible physiopathogenesis of pain mechanisms was also carried out.

Abstract #35825 Table 1 Common target genes between 'Chronic Pain', 'Inflammatory pain' and 'Neuropathic Pain'

Genes in common in Chronic and Inflammatory Pain		Genes in common in Chronic and Neuropathic Pain	Genes in common Inflammatory and Neuropathic Pain	Genes in common in Chronic, Inflammatory and Neuropathic Pain
BDNF	MAPK1	SERPINA1	TAC1	TRPV1
COMT	PENK		NOS2	CALCA
NGF	PRKCA		AGT	IL1B
P2RX3	PIK3CG			SIGMAR1
OPRM1	POMC			IL10
P2RX7	PIK3CB			
GRM5	PIK3CA			
DUSP2	PIK3CD			
P2RX2	CX3CL1			
ACACA	AIMP2			
BMS1	PTGES			
GJA1	GRAP2			
IL6	ASIC3			
TRPM8	CCR2			
P2RX4	CCL2			
CRH	P2RY12			
PSMG1	SLC6A9			
ADCYAP1R1	DNMT3A			
KLF6	GRK2			
TRPA1	FKBP5			
CSF1	FKBP4			
CNR2	ADRA1A			
PTGS2	MTCO2P12			
SLC12A5	AHSA1			
MAPK14	CACNG2			
CRK	CDK5			
ATPSCKMT	NLRP3			
CNR1	ADCYAP1			
MGAT1	POLDIP2			
ARRB2	RNF19A			
LEP	CXCR3			
KNG1	HTR1A			
CXCL10	GRM4			
NPY	MTOR			
COX2				
GH1				



Abstract #35825 Figure 1 Common target genes between 'Chronic Pain', 'Inflammatory pain' and 'Neuropathic Pain'. Obtain from Venny 1.0.2

Results In the bioinformatic analysis, we identified through the DisGeNET database around 207 genes related to chronic pain, 266 genes in inflammatory pain, and 24 genes in peripheral neuropathic pain. The Venny 2.1 online platform was used to find common genes between these pathologies, identifying around 78 common genes. An interaction network was built on the STRING platform for these 78 genes. The pathways discovered through this analysis include inflammatory mediator regulation of TRP channels, the VEGF pathway, neuroinflammation, and the relationship between COX2 and EGFR. Among the principal explanations for the physiopathogenesis in the literature, the accumulation of Gb3 in the sacral plexus, the activation of the Notch 1 pathway, and the function of ion channels (KCa3.1 channels) are involved in the mechanism of initiation.

Conclusions This analysis aims to explain unresolved key pathophysiologic features of pain without discarding the possibility of additional genomics factors and providing future investigation opportunities.

#36161 REGIONAL ANESTHESIA AS PART OF A MULTIMODAL BLOOD CONSERVATION STRATEGY IN A JEHOVAH'S WITNESS

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Background and Aims Preoperative optimization of anemia is particularly important in Jehovah's Witnesses before major surgery. However, when presenting in an acute setting there are no recommendations, and a multimodal and multidisciplinary approach is necessary to safely deliver treatment. Regional anesthesia has a particular role in reducing complications.

Methods Case report.

Results A 74-year-old male was admitted in our institution for above-knee amputation of the left lower extremity due to irreversible ischemia. His past medical history was relevant for multiple myeloma, hypertension and type 2 diabetes mellitus. His baseline hemoglobin was 7.7 g/dL. He was a Jehovah's Witness who refused blood transfusions, having been transferred from another institution, where he was denied surgery. Two days before surgery, ferric carboxymaltose 500 mg was administered. Surgery was performed under combined spinal-epidural anesthesia, with 7 mg of intrathecal hyperbaric bupivacaine. Before the beginning of surgery, tranexamic acid 1 g was administered. Hemodynamic stability was achieved, with minimal blood loss (200 mL). The final hemoglobin was 6.4 g/dL. For postoperative analgesia a multimodal approach was implemented, with patient-controlled epidural analgesia with ropivacaine 0.2%. After surgery, darbepoetin alfa 500 micrograms was administered. He was transferred back to his original institution after two days.

Conclusions Lower extremity amputation carries a significant risk of perioperative morbidity and mortality. Regional anesthesia may confer several advantages over general anesthesia, having demonstrated a reduction of blood transfusion