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

<table>
<thead>
<tr>
<th>INTERUPT/INT</th>
<th>MANAGEMENT</th>
<th>NEURALGIA ANESTHESIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>NO</td>
<td>With Aspirin ≤ 100 mg</td>
</tr>
<tr>
<td>clopidogrel</td>
<td>Yes (if patient has high thrombotic risk)</td>
<td>With clopidogrel ≤ 100 mg, neuraxial anesthesia can be performed</td>
</tr>
<tr>
<td>AVK</td>
<td>Yes (if high thrombotic risk patient add heparin as bridge therapy)</td>
<td>With AVK dose ≤ 5 mg/kg/h and no antithrombotic drugs</td>
</tr>
<tr>
<td>Delegaran</td>
<td>Yes</td>
<td>Check renal function</td>
</tr>
<tr>
<td>Anticoagulants (bridging, oral anticoagulants)</td>
<td>Yes</td>
<td>Check renal function</td>
</tr>
</tbody>
</table>

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

**#35961 COMBINED ANESTHESIA FOR TRANSABDOMINAL VERTICAL RECTUS ABDOMINIS MUSCULOCUTANEOUS FLAP**

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10.1136/rapm-2023-ESRA.A421

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** 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 0.23% 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 cetrohalog 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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10.1136/rapm-2023-ESRA.A422

Please confirm that an ethics committee approval has been applied for or granted: Yes: I am 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 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 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 personnel are important at the end of life.

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

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10.1136/rapm-2023-ESRA.A423

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 Fabry disease is an X-linked disorder caused by mutations in the GLA gene, leading to globotriaosylceramide (Gb3) accumulation on the lysosome. Patients experience various 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.

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.