

#35956 A RARE CASE OF LAST AFTER FEMORAL NERVE BLOCK UNDER USG GUIDANCE -A CASE REPORT

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10.1136/rapm-2023-ESRA.431

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Background and Aims This is a case report of a rare incident of possible LAST after a femoral nerve block in an 80-year-old female with intertrochanteric fracture of femur.

Methods The patient was on dual antiplatelets and CRF patient requiring dialysis 3 days a week. A rt femoral nerve block was planned with 20 ml 0.25% bupivacaine for pain relief. After scanning the inguinal region and identifying femoral nerve an 8 cm echogenic 22 G needle was directed near the femoral nerve after piercing the fascia, aspiration was done to see any blood .20 ml of 0.25% bupivacaine was injected in aliquots of 5 ml and aspiration was done after every 5 ml.

Results After 10 minutes patient started having abnormal involuntary movements and patient complained of perioral distaste and earache. The patient was hemodynamically stable but intermittent VPCs were noted in EKG. A clinical diagnosis of LAST was made and 1 mg of midazolam was given initially to control the involuntary movements. An initial bolus of 50 ml of 20% intralipid was given as a bolus intravenously in 10 minutes considering her age and comorbidities though the presentation was not mandating administration of intralipid. The involuntary movements decreased gradually and in 15 minutes patient became completely conscious and EKG became normal.

Conclusions A high degree of suspicion is required to anticipate LAST as it can present in different ways .20% intralipid has to made available in all areas where a regional anesthesia technique is used.

#35807 ERECTOR SPINAE BLOCK FOR PERCUTANEOUS KYPHOPLASTY ANESTHETIC MANAGEMENT IN HIGH-RISK PATIENTS: A CASE REPORT

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10.1136/rapm-2023-ESRA.432

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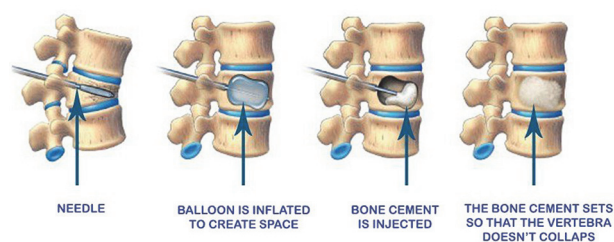
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Background and Aims Kyphoplasty for osteoporotic vertebral compression fractures (OVCF) is a short but painful intervention. Several anesthetic techniques (local, regional (paravertebral block (PRV)/Erector Spinae block (ESP) or general

anesthesia(GA)) have been proposed to control pain during kyphoplasty, although in our center GA is preferred.

Methods A 76-year-old male, with T11 OVCF and intractable pain was proposed for kyphoplasty. Medical history: ASA IV, dilated cardiomyopathy (left ventricular ejection fraction 15%), myasthenia gravis, COPD Gold 4, obstructive sleep apnea, obesity (BMI 35), hypertension and diabetes mellitus. Patient was initially turned down for kyphoplasty due to the high anesthetic risk of GA, but the pain was unbearable. We decided underwent surgery under bilateral ESP at T11 level in prone position using ropivacaine 0,5% + dexamethasone 4mg (20ml/side) without sedation.

Results The procedure was well tolerated by the patient, without any sedation. No postoperative complications occurred. Numerical rating pain scale (NRPS) were before/during/24 hours and month postoperatively: 10/0/2/1. Patient was discharged the day after surgery. Kyphoplasty was successful improving pain, mobility and quality of life.



Abstract #35807 Figure 1 Kyphoplasty procedure

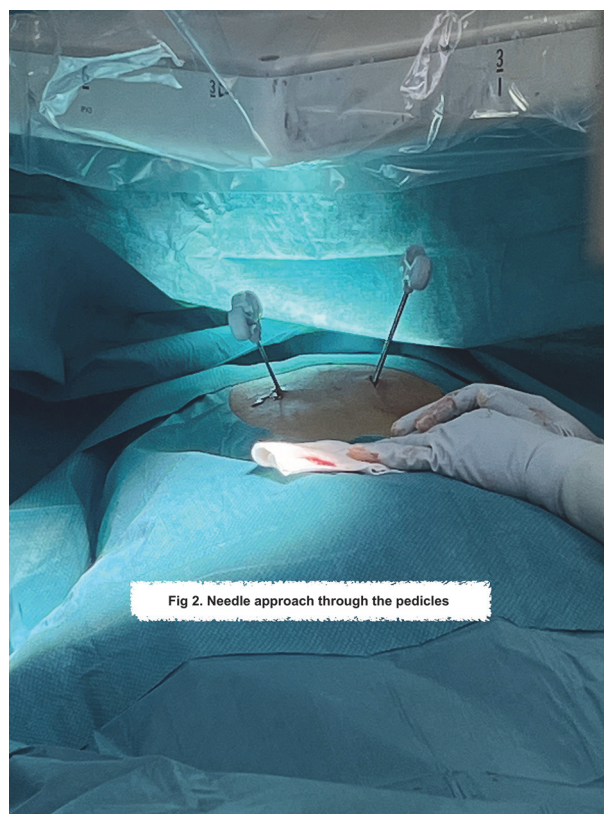


Fig 2. Needle approach through the pedicles

Abstract #35807 Figure 2 Needle transpedicular approach for kyphoplasty