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 Psychogenic nonepileptic seizures are unusual events that may occur in the perioperative period. It can mimic other complications causing confusions and misdiagnosis to regional anesthesiologist.

Methods Case of a 24 yo female for Open Reduction Internal Fixation of Ankle for Closed Distal Fibular Fracture Right. General Anesthesia with Ankle Block was done after consent. Intraoperatively, after induction and regional block performed, patient was stable all throughout the procedure. Surgery lasted for 3 hours. Patient was transported to the recovery room, uneventful.

Results 30 minutes postoperatively, patient developed signs of irregular uncontrolled movements, upward rolling of the eyes with no verbal response. Shivering and Seizure after local anesthetic toxicity were immediately considered with benzodiazepine and Lipid Emulsion initiated. Repeated attacks were recorded until 72 hours post operatively with an interval in between of intact sensorium and orientation. Attacks were noted to be triggered by severe pain. The longest duration noted to be was 25 minutes. However resistance to anticonvulsants, benzodiazepines were eventually noted. A 12 hour video Electroencephalogram was done with 2 attacks captured during the procedure and revealed a normal result. A psychogenic nonepileptic seizure was then considered until discharged.

Conclusions Psychogenic nonepileptic seizures are rare with 1.4 per 100 000 and an estimated prevalence of 2-3 per 10000. Knowledge and correct diagnosis is of tantamount importance to anesthesiologists to prevent morbidity and mortality brought about by anticonvulsive therapy such as respiratory depression, risk and injury brought by tracheal intubation, with prolonged hospital stay and added costs especially in this third world country.

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Background and Aims Intrathecal administration of wrong drugs (IAWD) can have catastrophic consequences. Reported IAWD in literature are mainly individual cases or small case-series reports. In most of them cerebral spinal fluid lavage (CSFL) seems to be a choice of management, added to support measures. The aim of this work is to know if CSFL could be considered as a safe and effective treatment in case of IAWD.

Methods The author searched published reports of IAWD using Pubmed database from January 2017 to January 2023. Those in which CSFL was used as a treatment were selected. The main study founded was a review article that identified potential sources of IAWD and its appropriate management. Other studies described individual cases of IAWD managed with CSFL.

Results Immediate CSFL is related to good outcomes in many of the studies reviewed. It involves CSF aspiration with a spinal catheter or a needle at the volume of 10-20 ml each time and replaced with an equal volume of normal saline, so the drug is diluted and removed. It’s usually make in emergency situations so it’s difficult to perform a proper randomized clinical trial evaluation. Maybe that’s why it is not considered as a standard treatment for IAWD.

Conclusions Despite of the lack of studies published, early CSFL should be considered, in addition to supportive and symptomatic treatment, especially if life-threatening consequences are anticipated. It is needed to balance the risks and benefits case-by-case before using CSFL, but does not seem to have major complications in an emergency situation.

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Background and Aims The main goal of an epidural test dose (ETD) is to avoid the inadvertent injection of large doses of opioids and local anaesthetic either intravascularly, subduraly or intrathecaly. Although some literature suggests that the ETD is not an effective method for identification of epidural catheter (EC) misplacement in obstetrics, it is still common practice in many maternities.

Methods We review 3 clinical scenarios of complications after the administration of epidural anaesthesia or analgesia, where the ETD failed to reveal the catheter misplacement.

Results The first case report refers to a pregnant woman who received a sequential block for labour analgesia. An ETD with lidocaine was administered after the technique. One hour later an epidural dose for analgesia was administered, which caused a complete motor block with hypotension and fetal distress. The second case describes an epidural technique for labour analgesia, followed by an uneventful ETD with lidocaine and epinephrine. Shortly after a ropivacaine bolus, the patient developed a patchy block and a Horner syndrome. The third case refers to a caesarean section with an EC already in place, tested with a lidocaine bolus. After the administration of ropivacaine for surgical anaesthesia, the patient developed severe respiratory distress with the need for mechanical ventilation.
Conclusions There are many cases in literature where the ETD was ineffective and even associated with adverse events. These three case reports show that the ETD does not prevent the occurrence of adverse outcomes. More studies are required to establish which strategy is valid for early detection of EC misplacement.

Background and Aims Adhesive arachnoiditis (AA) is a chronic, rare and debilitating disease. Characterized by persistent arachnoid inflammation leading to intrathecal scars and dural adhesions, resulting in ischemia, encapsulation, and atrophy of nerve roots. Clinical manifestations include chronic back pain and variable neurological deficits. Anaesthetic challenges include chronic pain management, baby withdrawal syndrome and difficult neuraxial approach.

Methods A 39-year old pregnant woman was scheduled for elective cesarean section due to maternal pathology. Presently with adhesive arachnoiditis, severe lumbosciatalgia, and treated pregestationally with hydromorphone, morphine, baclophene, gabapentine and diazepam. Showed neurologic deficits such as gait impairment, urinary incontinence, spasticity and paresthesia of the lower limbs. Other relevant history included: Chiron’s disease, asthma, obesity, gestational diabetes and multiple previous vertebral procedures. General anesthesia was induced using propofol and rocuronium, and maintained with sevoflurane. Tracheal intubation accomplished through video-laryngoscopy. Intraoperative analgesia included fentanyl, paracetamol and ketorolac. Multimodal postoperative analgesia was ensured, combining a bilateral TAP block using ropivacaine, paracetamol, ketorolac and a fentanyl Patient Controlled Analgesia (PCA).

Results Successful cesarian section performed under general anesthesia, with no complications for mother or baby. Postoperative daily evaluation revealed mild pain and nausea, treated effectively with ondansetron. Fentanyl PCA was suspended 48 hours postoperatively.

Conclusions AA patients can be challenging for the anaesthesiologist due to limitations in the neuraxial approach – an especially important anaesthesia technique in labour – and the management of postoperative acute pain in a patient with chronic pain. The described approach may be a safe and effective choice for AA patients undergoing cesarian section.

Abstracts

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Background and Aims Placenta percreta is a severe form of placental accretion in which the placenta penetrates the entire uterine wall and attaches to other organs, raising the risk of obstetric haemorrhage, peripartum hysterectomy, along with maternal and fetal mortality. We report a challenging case of a multidisciplinary approach to massive bleeding following a placenta percreta diagnosed during the cesarian section.

Methods A 35-year-old, G2P1 (previous cesarean) and 30 weeks gestation pregnant woman was diagnosed with placenta percreta during an emergent cesarean under spinal anaesthesia due to imminent premature labour. General anaesthesia was performed, and as the caesarean began, a massive haemorrhage survene. The multidisciplinary team and the transfusion protocol were activated and guided by viscoelastic tests. The transfusion therapy included: 5 red blood cell transfusions (SUCE), fibrinogen (4g), tranexamic acid (2g) and crystalloids (4L). Vasopressor support under invasive monitoring (30mcg/min) and, ultimately, the hysterectomy were required to control the bleeding. A total blood loss of 2500mL was estimated.

Results The patient was transferred under invasive mechanical ventilation to an intensive care unit. On the third postoperative day, the patient developed a post-hysterectomy hematoma, and thromboembolism prophylaxis was not started. Two days after, she developed pulmonary thromboembolism and started anticoagulation, receiving hospital discharge on the seventh postoperative day.

Conclusions Placenta percreta is a life-threatening clinical entity where multidisciplinary teamwork and a careful preoperative plan are crucial to success. Our case was handled with a prompt and effective response during an unforeseen event with success.

Attachment Isabel Ramalho (1).pdf

Abstracts

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Background and Aims IDIOPATHIC PULMONARY ARTERY HYPERTENSION (IPAH) POSTED FOR LOWER SEGMENT CAESAREAN SECTION (LSCS) – A CASE REPORT

Raju Jadhav*, Department of Anesthesiology and Intensive Care, North Cumbria Integrated Trust NHS, Whitehaven, UK

Results The patient was transferred under invasive mechanical ventilation to an intensive care unit. On the third postoperative day, the patient developed a post-hysterectomy hematoma, and thromboembolism prophylaxis was not started. Two days after, she developed pulmonary thromboembolism and started anticoagulation, receiving hospital discharge on the seventh postoperative day.

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Background and Aims IPAH corresponds to sporadic disease without any family history of PH or known triggering factor with mPAP > 25 mm Hg or more at rest after excluding left sided heart disease and certain other disorders.[1] Pregnancy in IPAH patients is associated with very high peri-partum mortality and conception is not advised and if detected early in pregnancy, then termination is advised.[2]

Methods Parturient, 37 years, at 35 weeks gestation, premature labour was referred to us being diagnosed as IPAH-NYHA Class III, on Tab.Sildenafil 12.5mg BD and Inj.Enoxaparin 40mg s.c. Post high risk consent, LSCS done under lumbar

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